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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC. • JANUARY 1975

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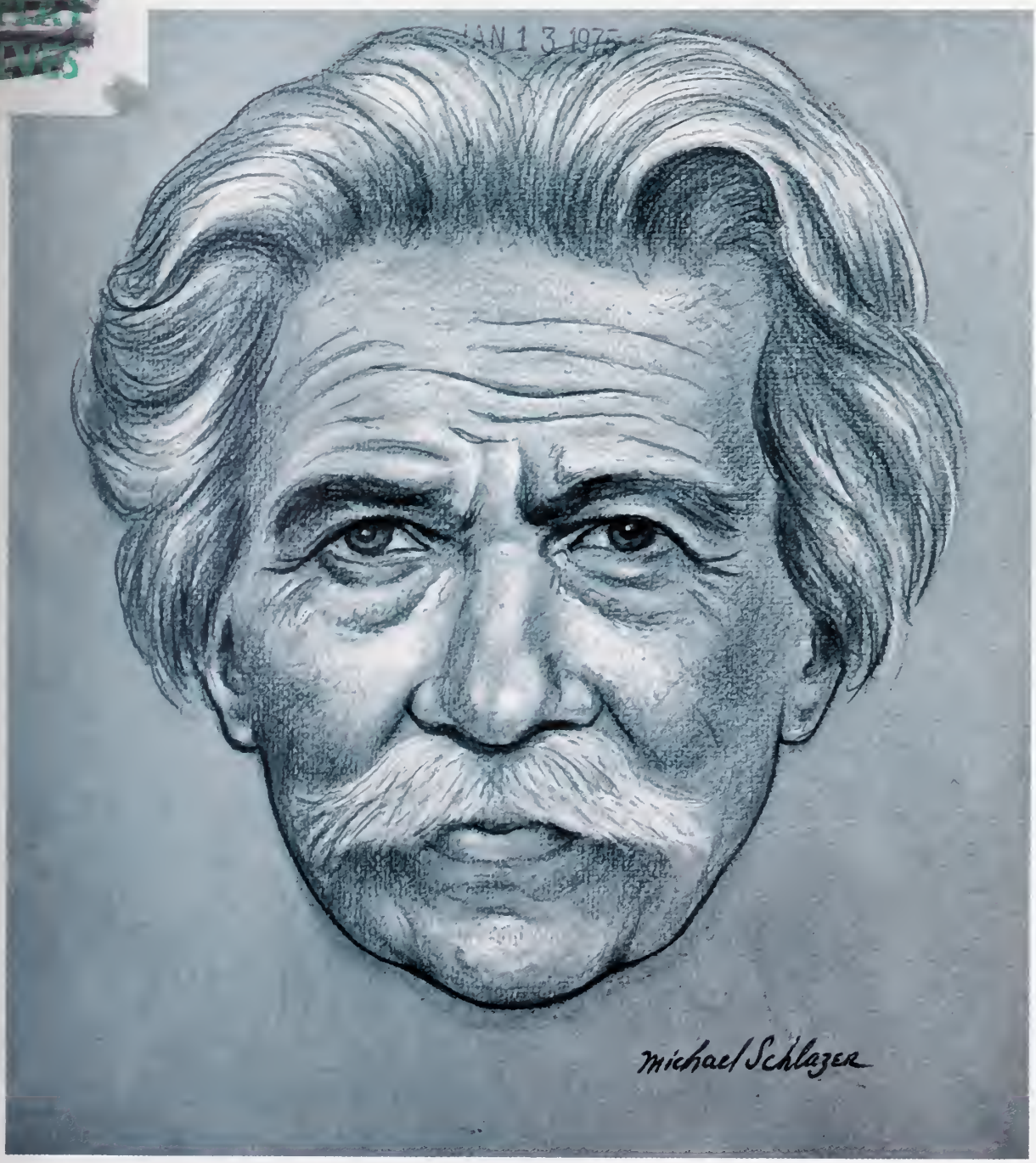
BOSTON

JAN 13 1975



Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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JAN 1 3 1975

respond to one

According to her major
ptoms, she is a psychoneu-
patient with severe
ety. But according to the
ription she gives of her
ngs, part of the problem
sound like depression.
is because her problem,
ugh primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
gy. Valium (diazepam)
provide relief for both—as
xcessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.
There are other advan-
in using Valium for the
agement of psychoneu-
anxiety with secondary
essive symptoms: the
hotherapeutic effect of
um is pronounced and
l. This means that im-
ement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

illance because of their predisposi-
habituation and dependence. In
ancy, lactation or women of child-
ng age, weigh potential benefit
st possible hazard.

utions: If combined with other psy-
opics or anticonvulsants, consider
ully pharmacology of agents em-
d; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
ther antidepressants may potentiate
tion. Usual precautions indicated in
nts severely depressed, or with latent
ssion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Albert Schweitzer Remembered
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January Cover—Artist's conception of Albert Schweitzer by Mr. Michael Schlazer, painter, illustrator and teacher, of Miami. See Albert Schweitzer Remembered, page 13.

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

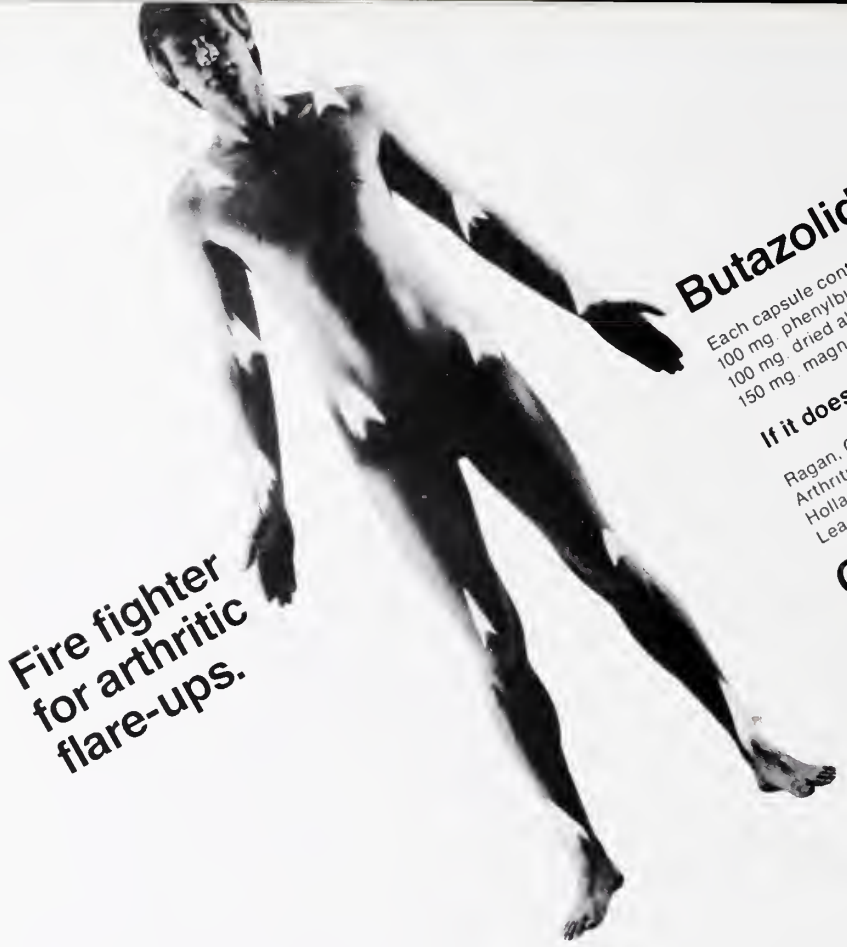
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



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Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less, senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias, renal, hepatic or cardiac dysfunction; hypertension; thyroid disease, systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

President's Page

"And Above All Appreciate"

In addition to our primary concern—the wellbeing of our patients—we physicians have been concerned with many other problems in the past year.

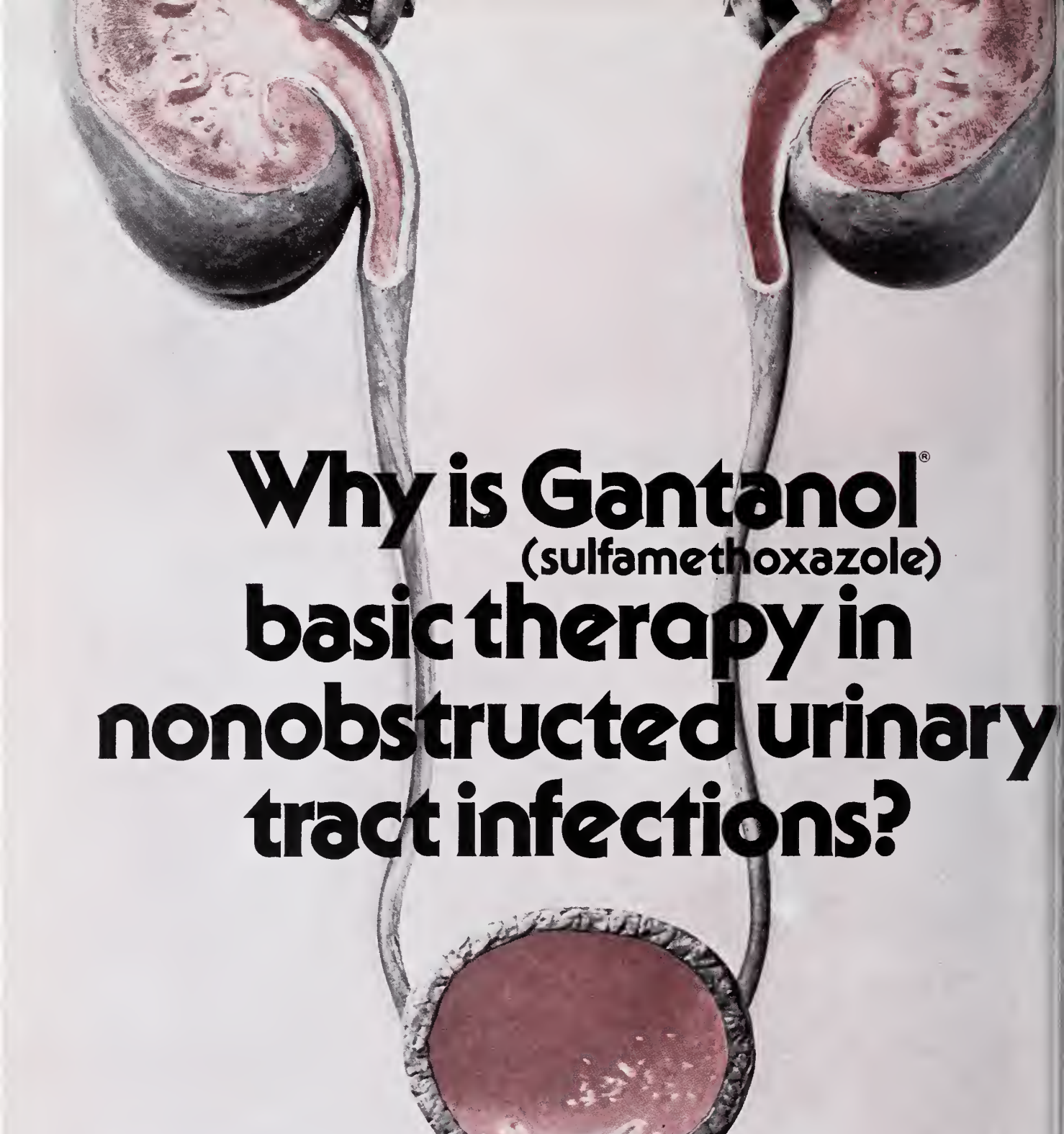
We have thought about, written about, and discussed the patterns of medical practice, patient/physician relationships and nonprofessional interest in medical services. We have been skeptical of government decisions concerning patient care, fee levels, and nonprofessional participation in health planning. We have sought better ways of financing and delivering medical care. We have worked toward a better distribution of health manpower, geographically and by specialty. We want to make proper medical care available to all.

Information has bombarded us concerning our problems; proposed solutions have almost overwhelmed us. Many people believe it their obligation to tell us how best to do our job, while they retreat into the security of social planning, while others do understand our difficulties and have the knowledge and ability to help us search for solutions.

We should be concerned with these problems but not to the exclusion of other considerations. We must take the time to appreciate the advantages we enjoy as citizens of the United States and as participants in the profession we have chosen. Within the limits of accepted standards, we practice as we wish, in locations selected by us. We have the freedom to enjoy the advantages of twentieth century technology and a standard of living unknown to most of us as children. We are still free to participate in and contribute toward the solutions to our problems. Our medical knowledge and ability are envied by our colleagues all over the world. Many of them would be in our places.

It has been said that for every man who gets something he does not work for, another works for something he does not get. In this year, 1975, let us earn what we get and above all, let us appreciate what we rightfully earn.

Thad Moseley



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
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Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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Medical News

BOULWARE LIBRARY DEDICATED . . . A new library and conference room devoted to pediatric medicine was dedicated at the University of Florida's J. Hillis Miller Health Center in October.

The library is named in honor of an early Florida pediatrician, James Richmond Boulware, M.D., of Lakeland who in 1968 initiated planning for establishment of the facility with an endowment of $10,000.

Among those participating in the dedication were FMA President Thad Moseley, M.D., Jacksonville, and U. S. Sen. Lawton Chiles of Lakeland who once was a patient of Dr. Boulware.

THREE M.D.'s GET VOTER NOD . . . Named to his first term as representative from District 97 was David J. Lehman Jr., M.D., of Hollywood. Re-elected were District 68 Rep. Richard S. Hodes, M.D., Tampa; and Walter W. Sackett Jr., M.D., in District 110. Republican Rep. F. Eugene Tubbs, M.D., Merritt Island, passed up a chance for a third term in the Legislature to wage an unsuccessful primary race for State Treasurer earlier this fall.

In Florida's U.S. Senate race Belle Glade physician John L. Grady M.D., garnered more than 271,000 votes as the American Party candidate, but he was outdistanced by the winner, Richard Stone and the runner-up, Republican Jack Eckerd.

TAMPA GETS FIRST AMA COURSE . . . The first in a series of AMA-sponsored regional postgraduate programs will be conducted in Tampa February 8-9, with others scheduled later for Phoenix, Minneapolis and Williamsburg, Va. Eight courses will be conducted at Tampa's Host Airport Inn and Admiral Benbow Inn: They are: Fluid and Electrolyte Balance; Infectious Diseases and Antibiotics; Dermatology for Non-Dermatologists; Pulmonary Function and Blood Gases; Human Sexuality; Basic and Advanced Life Support—Cardiopulmonary Resuscitation (CPR); Venereal Disease; and Basic Electrocardiography. All but the CPR course will last six hours and will be given both days. CPR is longer and will extend over both days.

Other information may be obtained by contacting the Department of Scientific Assembly, AMA, 535 North Dearborn Street, Chicago, Ill 60610.

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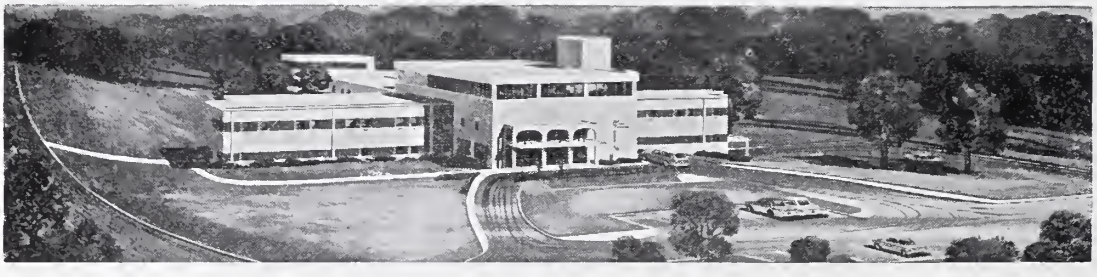

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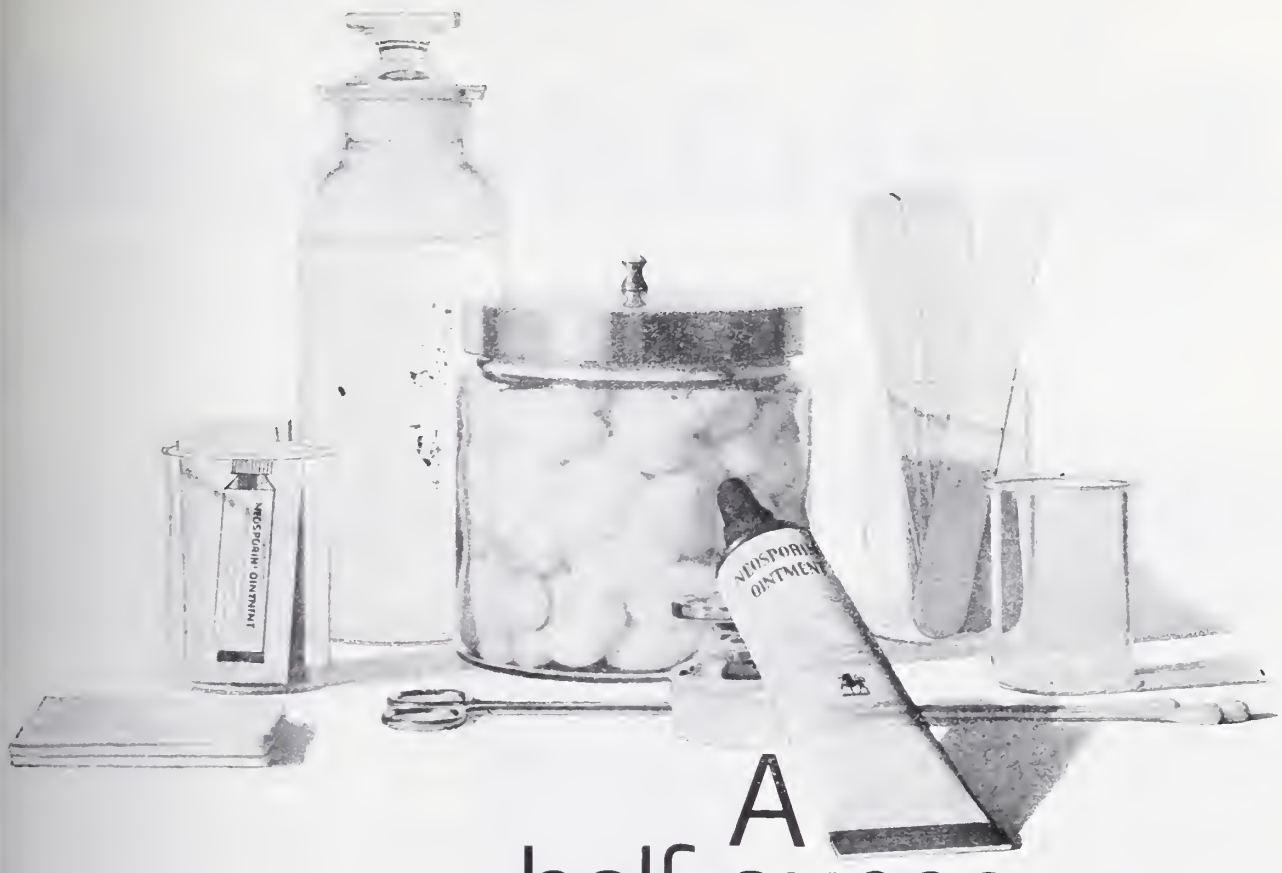

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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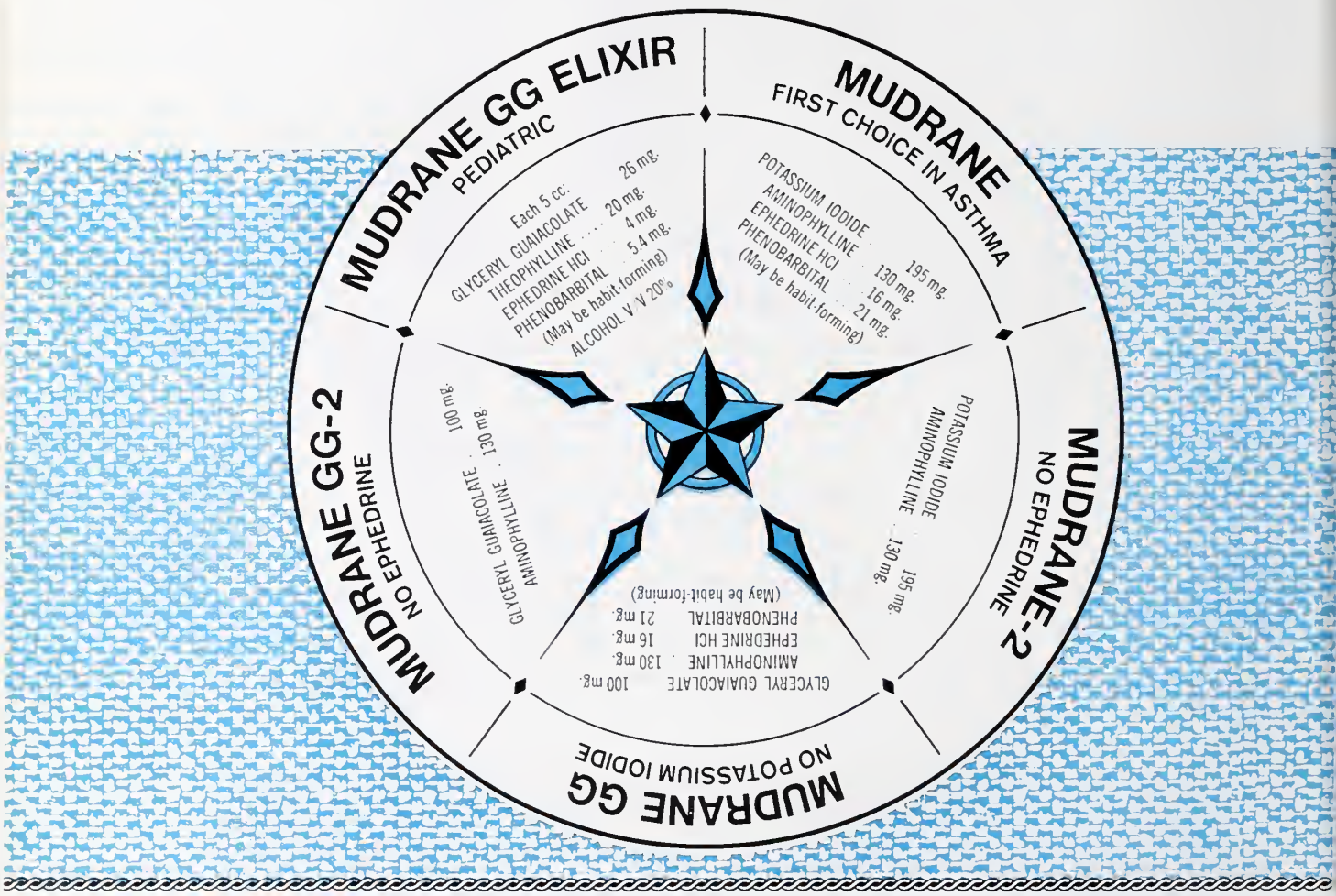

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CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

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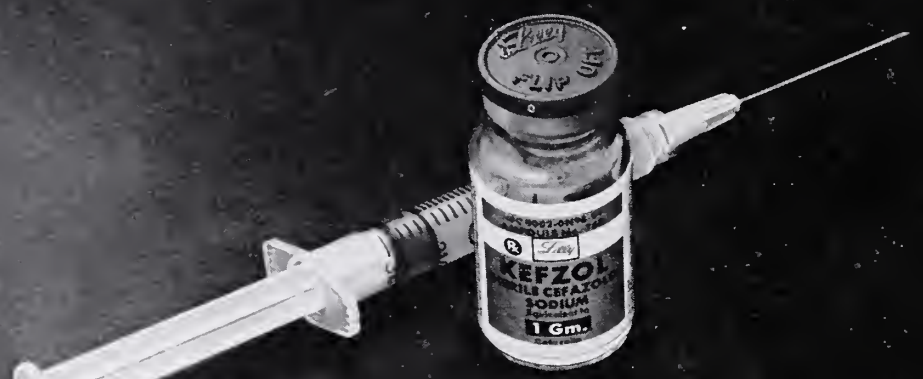

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THE JOURNAL
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JANUARY, 1975 • VOLUME 62 • NUMBER 1

Special Article

Albert Schweitzer Remembered

I. Leo Fishbein, M.D.

Most of the world notes the 100th anniversary of the birth of the great, humble renaissance man, Albert Schweitzer, M.D., Ph.D., on January 14, 1975. At 38 years of age, he, who established a singular direction for the reverence of life, chose Lambarene in the Gabon Province of French Equatorial Africa as a headquarters from which to serve with an abundance of personal resources —medical, spiritual, philosophical and religious. It is the accomplishments of these 52 years which the world most remembers. He died less than a decade ago. His example of sacrifice and fellowship has inspired the establishment of hospitals in other parts of the world—Haiti, Peru, North Carolina. In them, physicians and other men of goodwill provide training and share their talents so that patients regardless of age, income or race may benefit from modern therapy without politics, diplomacy or intrigue.

Albert Schweitzer showed that one man highly motivated and possessed with a singleness of aim and dedication can move the world on its axis. His own lever was long enough and sturdy enough to bring about changes that made the difference between despair and hope, faith and irony, honor and misery. His character, however, had been forged out of the services of generations of men who had instilled in him the values he lived by in a world which appeared concerned only with power.

Schweitzer was born in Kayserburg, Alsace, on January 14, 1875. The town was named for a famous preacher of the 15th century. His father was a Lutheran minister at the Evangelical Church there and his mother was the daughter of a pastor. Later that year, the family moved to Gunsback. Albert was the second child, his sister was older by a year. He was sickly and yellow-faced for two years and ominous warnings were circulated that he might not live, but he became stronger from the third year and soon was enjoying the company of two other sisters and a brother. He loved the stories of family and relatives. Jagle, the local gravedigger, was "the terror of my childhood." He told weird tales of people with horns but "my father told me in comfort that only Moses had horns and he taught me music on an old square piano. At eight, he gave me a New Testament. I was fascinated by the many Bible stories, especially the Three Wise Men from the East."

In school he was a dreamer and had difficulty with reading and writing. At nine, he entered the Realshule at Munster, began to do better and gave lessons in mathematics to backward children, thus earning enough money to buy a secondhand bicycle.

"Once a year I was allowed in my father's study that smelled of books. I couldn't understand how he endured studying and writing. I had a horror of studies and writing." He developed a passion for goodness, honesty and justice from his mother. "This early influence upon me of the commandment not to kill or to torture other creatures is the greatest experience of my childhood and youth."

A shy, happy child he was surrounded by loving parents, sisters, a brother and fascinating grandparents. He was always listening and learning. His responsibility for life was growing and

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he was testing his temper in arguments. He was "saddened by the amount of misery in the world around me."

"Between 14 to 16, I was a nuisance to everybody through my passion for discussion. I was the disturber of every conversation. I wanted to argue out my ideas with grown-up people. The light and truth-seeking spirit of my grandfather awoke in me . . . But how often do I inwardly rebel!" At 15 he was taking lessons on the organ from Eugene Munch.

He went to church faithfully with his family and loved the fine old Silbermann organs that had been built in the early 18th century. When he was at the Gymnasium in Muhlhausen he lived with his Uncle Lou and Aunt Sophie. She made sure he practiced the piano.

His grandfather Schillinger was pastor of a church in Strasbourg. He allowed the lad to play the organ in his church and was a charming enthusiast for enlightment and science. "At sixteen, I was very much under my grandfather's thumb. The village boys did not accept me for they envied my advantages in the home, spiritually and otherwise. One boy commented, 'Yes, if I got broth to eat twice a week as you do I should be as strong as you are.' " By this time he was playing the organ at church services and also directing the orchestra and choir. He was a happy youth, yet had questions about the right to happiness.

"We must carry our share of the misery which lies upon the world. It is through the idealism of youth that man catches sight of the truth and in that idealism he possesses a wealth which he must never exchange for anything else."

At 18, he took lessons on the organ from the famous teacher, Widor, in Paris, and then completed his final year at the Gymnasium. He attended the University of Strasbourg and was very determined about his future careers. During military service of one year, he already was exploring the life of Jesus.

"As a young man, my main ambition was to be a good minister. I became the principal of the seminary. Christian theology became over complicated. I decided to leave the seminary to make my life my argument. I would advocate the things in which I believed in terms of the life I lived. Instead of vocalizing my belief in the existence of God within each of us I would attempt to have my life and work say what I believed . . . thinking more in moral and ethical evolutions, aware of the natural goodness within."

In his late teens, he was interested in organ construction, playing organ accompaniment for Bach cantatas and Passions. Music studies progressed well. At 21, he gave careful thought and consideration, "that I must not accept this happiness as a matter of course but must give something in return for it."

"At 21, I resolved to devote my life till I was thirty to the office of preacher, to science and to music . . . nine years to serve the arts, the rest in direct service to human need." At 24, he earned his first doctorate in philosophy with a thesis on the religious philosophy of Kant. At 26, he received a second doctorate in theology with treatises on the synoptic Gospels. He had been working on "The Quest of the Historical Jesus" for many years.

At 30 years of age, in 1905, he received a third doctorate, in music, with a monumental work on Bach. In Bach's compositions he found pure emotion and simplicity, religious mysticism and an act of worship. He wrote the book, "Jean Sebastien Bach: le musicien-poete," and became a famous musicologist and performing artist, as well as Europe's most promising theologian, New Testament critic and church historian. Now he announced that he would become a physician, a decision made in 1896, and then go to Central Africa to relieve the physical suffering of the despised and rejected black man. "As far as I can remember I was saddened by the amount of misery I saw in the world around me."

His deep sensitivity to pain and suffering is most evident in his thoughts. "No one must shut his eyes and regard as non-existent the suffering of which he spares himself the sight. Let no one regard as light the burden of his responsibility. Religion is ethics, a thinking experience. Conventional indifference to pain in the natural world is due to moral cowardice—the fear of being considered sentimental . . . Whoever is spared personal pain must feel himself called to help in diminishing the pain of others. Have I the inward right to pluck all the fruit that my hand can reach? . . . Humanitarian work to be done in this world should, for its accomplishment, call upon us as men, not as members of any particular nation or religious body. Man could supply compassion amidst raw brutal nature; man could be moral in an immoral world . . . There are no heroes of action, only heroes of renunciation and suffering."

Medical Practice

At 30 years of age, he entered the University of Strasbourg School of Medicine and the following year resigned his various university appointments. During the last two years of the six-year medical course, he preached each Sunday and wrote about the mysticism of Paul the Apostle, wrote and lectured about Jesus, and continued with his musical and literary works.

He obtained the M.D. degree in 1911, and the following June married his beloved fiancee, Helene Breslau, a Jewess, daughter of the history professor. She had become a nurse to aid him in his ambition to serve mankind in Africa.

He studied tropical diseases in Paris to prepare himself for practice in Africa and purchased minimal supplies there. In its magazine the Paris Missionary Society appealed for volunteers to go to the Congo Mission. Schweitzer applied as a physician but was turned down because of his liberal views. "I had Christian love but not the correct Christian belief."

In the spring of 1913, Schweitzer and his wife came to Lambarene to set up the clinic-hospital on the banks of the Ogowe River. The site was provided by the Paris Missionary Society; it was considered the most unhealthy spot on earth. An American missionary-physician, Dr. Robert Hamill Nassau, had established the Lambarene mission in 1876 and it had fallen into the hands of the Paris Missionary Society in 1892. The fowl house was the only structure that could be used, and it became the "hospital." The medical supplies Schweitzer brought with him had been derived from organ recitals and lectures and book royalties.

He built the clinic-hospital with his own hands, assisted by the natives, and began treating patients with diseases prevalent to the area: leprosy, hernias, ulcers, dysentery, sleeping sickness, tropical anemias, dental, mental and pregnancies. "My name among the natives is 'Oganga,' the fetishman. They have no other name for doctor, their own tribesmen are fetishmen. They believe that disease comes from evil spirits, malicious symptoms." In the first nine months he had close to 2,000 patients.

"I had the great desire to run the hospital in a simple way and to create a spirit that would perpetuate it. I am just a simple doctor. All I wanted to do was found a small hospital. But patients came and people gave me land, and people came to help. . . . When I came to Africa you didn't even need a passport. Old wives acted as midwives. Many women died in childbirth."

World War I came, and the French authorities declared that Alsatians were German citizens. The Schweitzers were interned as POWs on August 5, 1914. Four months later they were allowed to return to their hospital for the need was great. In 1917, they spent ten months in a POW camp in the Pyrenees and Provence. They were released in July 1918 and went to Gunsbach to recuperate.

Schweitzer returned to Lambarene in 1924 to find his hospital a mass of ruins. The jungle had overrun the place. With courage and perseverance he began reconstruction, serving as physician in the morning and masterbuilder the remainder of the day.

"A single doctor out here with the most modest equipment means very much for the many. We are the heirs of a complex civilization. It is up to us to make the light of truly humanitarian culture shine throughout the world. Only at rare times have I felt really glad to be alive. I could not but feel with sympathy full of regret all the pain that I saw around me, not only that of men, but that of the whole creation. From this community of suffering, I have never tried to withdraw myself."

The hospital received no formal assistance from any government. There was awe from a respectable distance that this doctor, citizen of the world, "man of individual action," had given human greatness to an age of mediocre leadership. Heroic doctors, nurses, social workers and friends came to help him. Money was collected and medical supplies were sent in gratitude and blessing. Service was the keyword, not glamour. To be sure, there were sightseeing tourists who wanted to know what was happening at Lambarene.

Schweitzer was amazed that the Africans had the great capacity to live with the impossible. He constantly reflected on the importance of the reverence for life and was haunted by the ocean of need in his little island of therapy. He barked and scolded but all understood the kind physician. Overnight visitors were appalled, but the staff enjoyed freedom from all the nonessential facets. The Europeans could do only half the work of the natives because of the climate. Many delicate instruments broke down under the heat and humidity. He made friends with the witch doctors and treated them with dignity as colleagues

in healing. He praised the extraordinary fortitude of the natives in their daily battles for security, survival and work.

"When I first went to Africa I prepared to make three sacrifices: to abandon the organ, to renounce the academic teaching activities to which I had given my heart, and to lose my financial independence, relying for the rest of my life on the help of friends. These three sacrifices I had begun to make and only my intimate friends knew what they cost me."

Lambarene became a "republic of the soul," an evangelical republic; the doctor and his staff held frequent religious services during the week and especially on Sundays. He was a combination of Mark Twain, Einstein, Teddy Roosevelt and the Pope. "There are wives of patients who come to be with their husbands. They help to pay for the treatment. If the wife is sick, the husband works so that every family makes a contribution of some sort to the hospital. We never turn a patient away. Christianity is practiced here for all to see. . . . If we made a modern hospital system with patients removed to alien surroundings, it would be too great a shock, because of the contrast with their normal surroundings."

Schweitzer served 13 sojourns in Africa, the final one beginning in 1957. In the intervening years he lectured at leading universities in Europe and received honors and funds to carry on his great projects. He gave concerts and toured Europe to bring the plight of the Africans to the world, seldom resting from his labors.

The Final Years

Schweitzer was awarded the Nobel Peace Prize on October 30, 1953, in absentia, since he was at his hospital post but the next year on November 4, he was in Oslo to deliver the Nobel Address on "The Problem of Peace in the World of Today." King Haakon and Helene Schweitzer heard him speak passionately in French for 50 minutes standing absolutely erect and 79 years young. Three years later, at age 80, she died and her ashes were returned to Lambarene to be buried outside his window at the hospital. His father had died in 1925 and his mother in 1916.

On September 4, 1965, in the hospital that had come to represent his entire life, le grand docteur died at age 90. He had chosen to die at Lambarene. "I feel at home here; I belong to you until my dying breath." His daughter, Rhena, survives.

The eulogies poured forth. "This century's greatest humanitarian, the apostle of mercy, now lies buried in a simple grave on the edge of civilization in Equatorial Africa. He leaves behind in Gabon few material memories. For half a century the quivering needle of Christian conscience, registering rebuke and challenge, has swung."

"He helped make it possible for twentieth century man to unblock his moral vision."

"There was undisputed grandeur in his view that 'a man is ethical only when life is sacred to him.' "

Queen Elizabeth II wrote: "His great work in so many fields will long be remembered and his humanity will inspire this and future generations."

Bertrand Russell stated: "Genuinely good and dedicated men are uncommon. Our age is hardly fit to understand them. It certainly does not deserve them. Dr. Schweitzer was both a good and dedicated man."

There has never been a dearth of criticism concerning Schweitzer and his hospital. The Gabon government considered the hospital "private" and did not give it official recognition. Gabon officials considered burning the place down and putting up a modern hospital. There was resentment for the belated and "reluctant concession to recruit African nurses," for the lack of sanitation and treating the natives in neocolonial style with too much paternalism and authoritarianism. Some felt that the individualistic self-sacrifice was not the most efficient way to serve the sick and helpless. Others said he did not groom a successor or convert a single African. The progressive Africans felt that their country had changed in the 50 years but that Schweitzer remained tied to his own old concept of Africans being incapable of governing their own countries in independence. No critic dared to deny that the doctor had performed great humanitarian miracles in the past half century.

The medical profession might have looked askance at his primitive and dogmatic treatment but its members were proud that the words "doctor" and "physician" meant so much to the world.

I am appreciative of the kind assistance granted me by librarians and staffs of the Calder Medical Library, Miami-Dade Community College, Mt. Sinai Medical Center of Miami Beach as well as the Miami Beach Public Library.

References are available from the author upon request.

Dr. Fishbein, 1688 Meridian Avenue, Miami Beach 33139.

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traindications: Diabetes mellitus that can be ulated by diet alone; hypersensitivity to phenin; renal disease with impaired renal funcn; a history of lactic acidosis; alcoholism; enile diabetes mellitus that is uncomplicated l well regulated on insulin; acute complicaıs of diabetes mellitus (metabolic acidosis, na, infection, gangrene); during or immedily after surgery where insulin is indispensable; ere hepatic disease; cardiovascular collapse ock); after disease states associated with oxemia.

rnings: Lactic Acidosis: There have been herous reports of lactic acidosis in patients eiving phenformin. This is an often fatal tabolic acidosis, characterized by elevated ate levels, an increased lactate-to-pyruvate o, and decreased blood pH. In most cases, temia ranging from mild to severe was pres-. This may have been the result of dehydra-. In some patients who developed lactic dosis, serum creatinine was later within nor- limits when the patients were properly hyted. Observe the following specific warnings:

mpairment of renal function increases the isk of lactic acidosis. Perform renal function ests, such as serum creatinine, prior to phenormin therapy and annually thereafter. Phenormin is contraindicated in patients with mpaired renal function.

Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
(B) 98-146-103-G (8/74)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

DBI 10450

Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

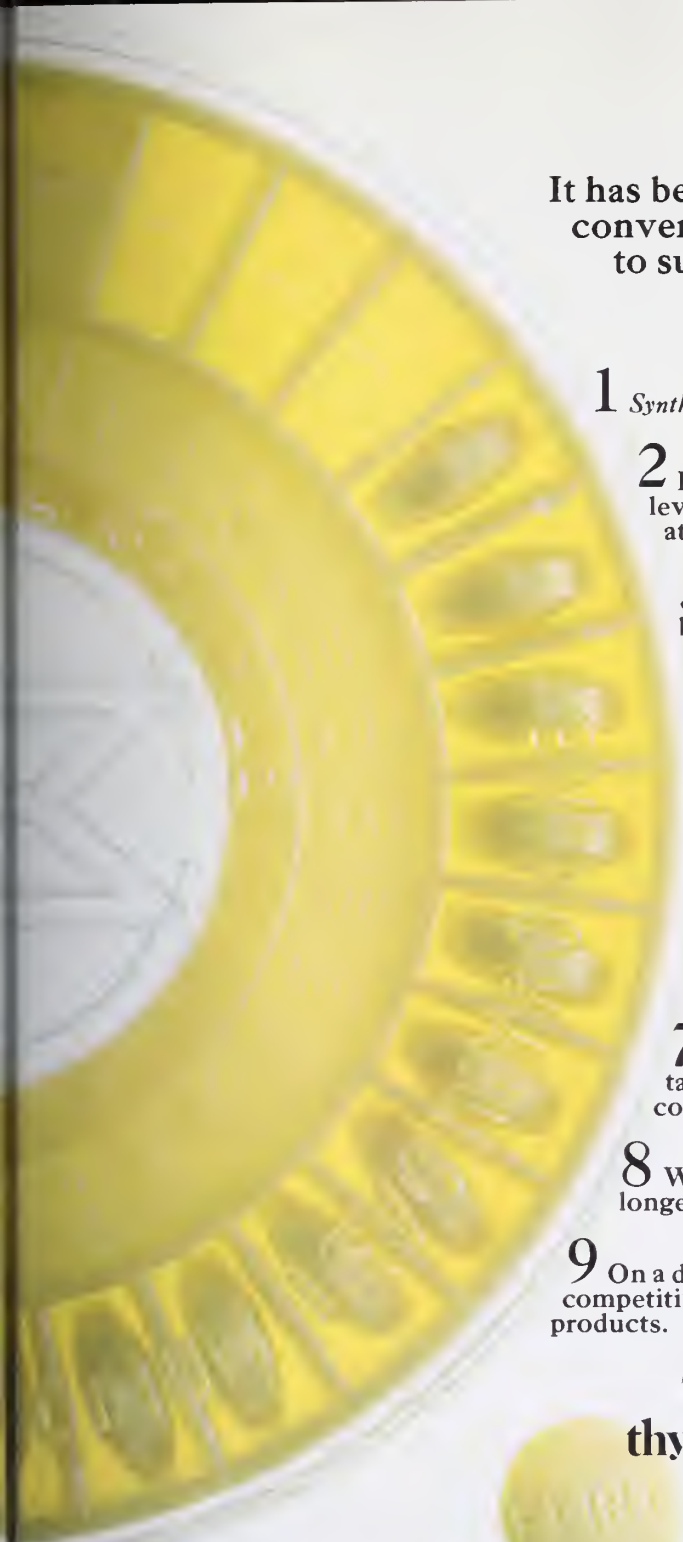
***Synthroid* is T_4.**
It provides your patients with what is needed for complete thyroid replacement therapy.

Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patie with cardiovascular disease; developmen chest pains or other aggravations of cardio cular disease requires a reduction in dosage

Contraindications: Thyrotoxicosis, acute myo dial infarction. **Side effects:** The effects of S THROID (sodium levothyroxine) therapy are s in being manifested. Side effects, when the occur, are secondary to increased rates of b metabolism; sweating, heart palpitations or without pain, leg cramps, and weight l Diarrhea, vomiting, and nervousness have been observed. Myxedematous patients w heart disease have died from abrupt increa in dosage of thyroid drugs. Careful observa of the patient during the beginning of any roid therapy will alert the physician to any toward effects.



It has been shown that *Synthroid* (T_4) converts to T_3 at the cellular level to supply metabolic needs. [1, 2]

1 *Synthroid* is T_4.

2 Because T_4 converts to T_3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

3 T_4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U.S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. 49:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. 51:3104-13, 1972.

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*PROFESSIONAL ADMINISTRATIVE PROCESSING SYSTEM – a combination of systems designed specifically for the Medical Profession to reduce voluminous paperwork and enable you to concentrate on the practice of medicine.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH DYAZIDE®

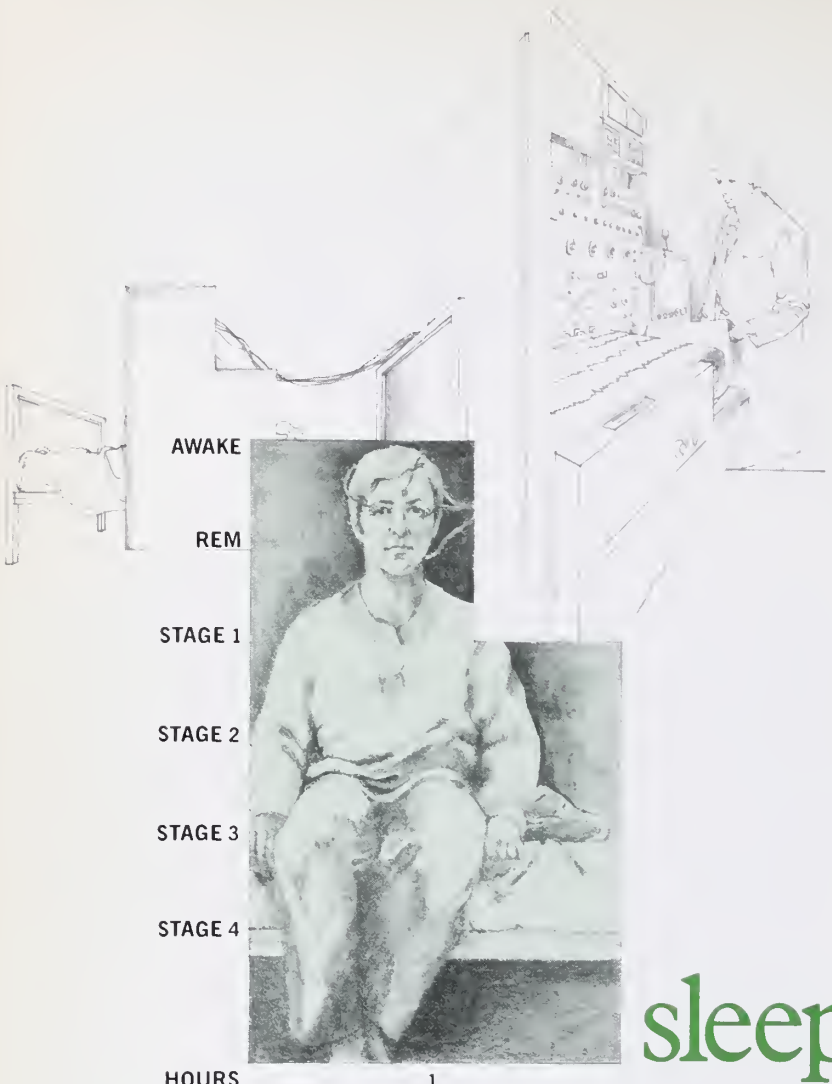
Trademark

Each capsule contains 50 mg. of Dyrenium (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Just 'Dyazide' once daily or twice daily
No inconvenient potassium supplements
Nor special K^+ rich diets needed as a rule

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



sleep begins within 17 minutes, on average...

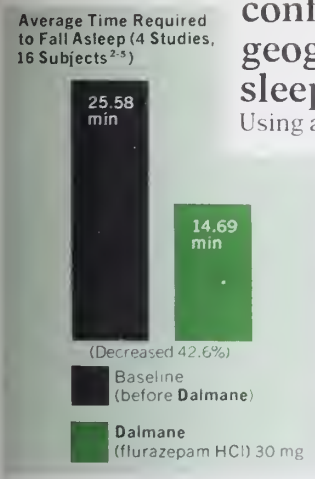
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

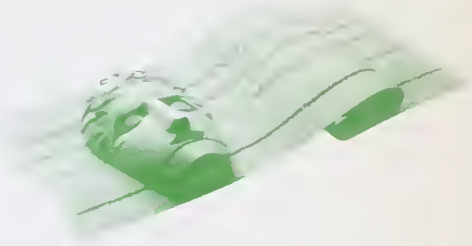
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and, or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al: Arch Gen Psychiatry 23:*226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When diarrhea has his number...

Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Usually stops diarrhea promptly.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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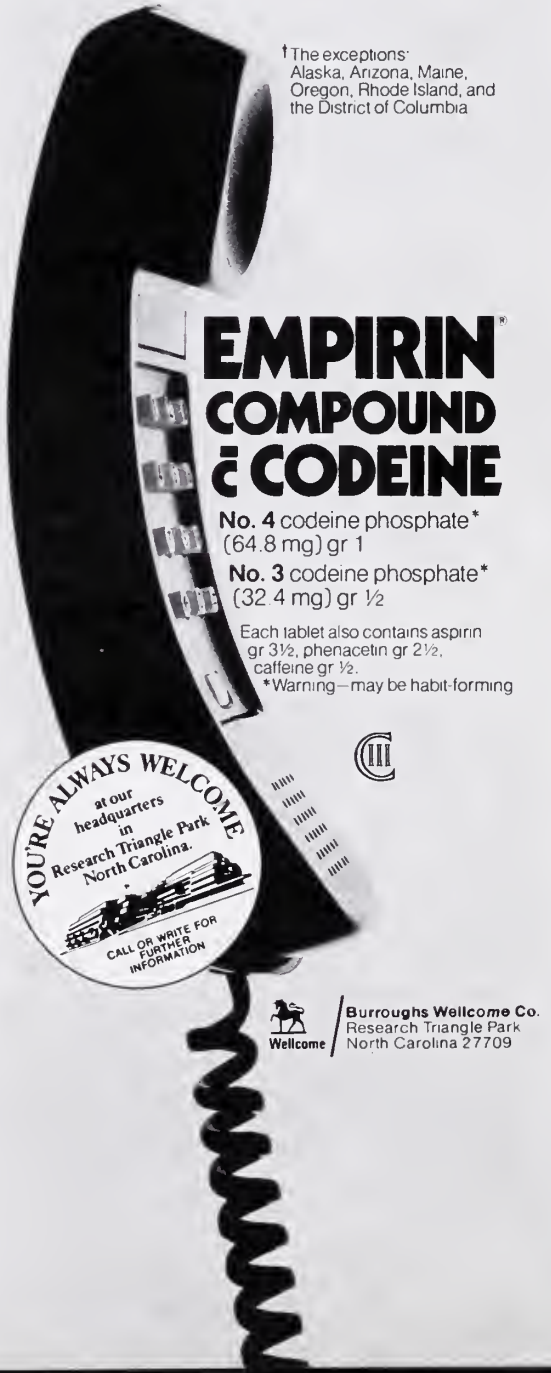
The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states†
That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

†The exceptions:
Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia



EMPIRIN® COMPOUND ℂ CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.
*Warning—may be habit-forming

Ⓒ III

Wellcome **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Editorial

A Time for Reflection

While life can only be understood backwards, it must be lived forward, and though the past cannot be changed, the future is in the hands of all of us. To both young and old a new year offers 8,760 hours, not one of which can be expanded, accumulated, mortgaged, hastened or retarded.

Sooner or later in everyone's life comes a a time when the conviction is reached that envy is ignorance and imitation is suicide; that one must take oneself for better or for worse and though the universe is full of good, no kernel of nourishing corn can come to one but through toil bestowed on that plot of ground given to him to till. Unafraid of what other people will say, adapting neither one's pace nor one's objectives to the pace or objectives of one's neighbor, thinking one's own thoughts, developing one's own hobbies, governed by one's own conscience, the only life worth living is the adventurous life. Sad is the day for one absolutely content with the life he is living, when there is no longer beating at the doors of his soul some great desire to do something larger, for individuals like "civilizations die when they no longer have a creative response to challenge."

The new year can be a time to toss away old hatreds, resentments, grudges and fears, a time to forgive and forget, a time to stretch one's soul, a time to dust off one's dreams and shine up one's ideals. So performing leaves one no time to waste in faultfinding, becoming discouraged or adhering to outworn traditions. Purpose can be added to one's year by rededicating one's self to those things which are enduring, recognizing that the greatest worth of life is to spend it on something that will outlast it.

In spite of the overthrow of governments by anarchy, starvation of nationals by excessive population growth or desolation of the civilized world from nuclear warfare, man will not only survive, he will prevail because he has a soul, a spirit capable of compassion, of sacrifice and endurance. As a divinely appointed guardian of all the powers evolved to man since time began; in the new year, it is one's duty to use these powers for man's continued growth and development and to pass them on renewed and enlarged to those who follow.

"Old age to the unlearned is winter, to the learned is harvest time." Life has many disasters and reversals but only one tragedy—to grow old without growing up. He lives life the fullest who extracts from knowledge the most wisdom, who gains from understanding more tenderness of heart, and who, from his mistakes, learns how to conduct himself with dignity.

C.M.C.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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- High potency B complex vitamins
- 500 mg. of vitamin C
- No odor
- No aftertaste

Each BEMINAL-500 tablet contains:

Thiamine mononitrate (Vit. B_1)	25.0 mg
Riboflavin (Vit B_2)	12.5 mg
Niacinamide	100.0 mg
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg.
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg
Cyanocobalamin (Vit. B_{12})	5.0 mcg.

Each tablet contains 0.15 mg. saccharin as sodium saccharin

Each tablet provides the following multiples of the recognized adult minimum daily requirements:

Thiamine mononitrate	25
Riboflavin	10
Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established.

USUAL DOSAGE: *Adults*—1 tablet daily, or as directed.

SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

7411

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.

The Role of the Detail Man

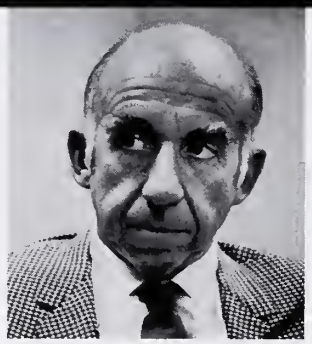
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likeliho on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
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- No odor
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Niacinamide	100.0 mg
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg
Cyanocobalamin (Vit. B_{12})	5.0 mcg.

Each tablet contains 0.15 mg. saccharin as sodium saccharin

Each tablet provides the following multiples of the recognized adult minimum daily requirements:

Thiamine mononitrate	25
Riboflavin	10
Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established

USUAL DOSAGE: *Adults*—1 tablet daily, or as directed.

SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100.

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anavac

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Sodium Lauryl Sulfate...25 Mg.
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Administration and Dosage: Adults: one or two tablets after the evening meal with a full glass of water. Children under 12: one-half tablet with fluid after evening meal.

Side Effects: May produce a discoloration of the urine. This is of no clinical significance. May appear in milk of lactating mothers.

Precautions: Frequent or prolonged use may result in dependence on laxatives.

Contraindications: Should not be used when nausea, vomiting, abdominal pain or other symptoms of appendicitis are present.

How Supplied: Bottles of 100 and 1000 orange, coated tablets.

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Vitamin A	2,500 U.S.P. Units
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Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
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Calcium Pantothenate	2.5 mg.
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Copper (from Copper Sulfate)	0.25 mg.
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As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

JANUARY

12th Annual Postgraduate Seminar in Anesthesiology, Jan. 2-5, Hyatt House, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Rd., Miami Beach 33140

Pediatric Nephrology, Jan. 2-7, Americana Hotel, Miami Beach*

Complications in Anesthesiology, Jan. 3-5, Hyatt House, Miami Beach*

Current Topics in Endocrinology—Current Concepts of Graves Disease, Jan. 3, A. Vance Morgan Educational Center, South Miami Hospital, Miami

Clinic Nights, Jan. 6-8, Biscayne Medical Center, Miami*

Neuro-Ophthalmology Seminar, Jan. 6-9, Doral Hotel, Miami Beach*

Topics in Clinical Pediatric Neurology, Jan. 9-11, Hyatt House, Miami Beach*

Infectious Diseases: Treatment & Prevention, Jan. 9-11, Hyatt House Hotel, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Pathology of the Oral Cavity & Its Management, Jan. 10-11, Fontainebleau Hotel, Miami Beach*

Newer Antibiotics, Jan. 21, Martin Memorial Hospital Trailer Conference Room, Stuart*

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Bal Harbour*

Special Procedures in Diagnostic Radiology: Basic and New Information, Jan. 12-16, Miami Beach Hyatt House**

Courses of Instruction in Coronary Care, Jan. 13-18, Jackson Memorial Hospital, Miami*

Seminar Session, Department of Anesthesiology, Jan. 16-17, University of Florida College of Medicine, Gainesville**

9th Annual Postgraduate Seminar in Surgery, Jan. 16-18, Sutton Beach Hotel, Miami*

Emergency Cardiac Care, 1975, Jan. 16-18, Americana Hotel, Miami Beach. For information: Emergency Medical Services Symposia, Inc., 1200 N.W. 10th Ave., Miami 33136

Pediatric Dermatology Seminar, Jan. 16-19, Carillon Hotel, Miami Beach*

Continuing Education in Pediatrics, Jan. 19-23, Diplomat Hotel, Hollywood. For information: Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Internal Medicine 1975, Jan. 19-24, Fontainebleau Hotel, Miami Beach*

1975 Ear Surgery Course, Jan. 20-22, Host Airport Hotel, Tampa International Airport. For information: J. Brown Farrior, M.D., 509 Bay St., Tampa 33606

Postgraduate Seminar in Pediatric and Adult Urology, Jan. 22-25, Hyatt House, Miami Beach*

17th Annual Cardiovascular Seminar, Jan. 24-25, Don CeSar Resort Hotel, St. Petersburg Beach. For information: Co. Heart Association, Box 12407, St. Petersburg 33733

Diagnostic Radiology for the Emergency Department Physician, Jan. 26-31, Key Biscayne Hotel, Miami. For information: Richard L. Bean, M.D., Memorial Hospital of Jacksonville, Jacksonville

Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31, Americana Hotel, Miami Beach*

20th Central Florida Medical Meeting, Jan. 29-Feb. 2, Contemporary Hotel, Lake Buena Vista (Orlando) For information: Orange County Medical Society, 800 N. Mills Ave., Orlando 32803

Current Computer Applications in Medicine, Jan. 31-Feb. 1,**

FEBRUARY

Seminar Session, Department of Anesthesiology, Mar. 3-7, University of Florida College of Medicine, Gainesville**

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 3-8, Americana Hotel, Miami Beach*

Current Topics in Endocrinology (CPC), Feb. 7, A. Vance Morgan Education Center, South Miami Hospital, Miami

Regional Postgraduate Courses by Council on Scientific Assembly, Feb. 8-9, Admiral Benbow Inn and Host Airport Hotel, Tampa. For information: Ms. Alice Harvey, Asst. Postgraduate Course Director, 535 North Dearborn St., Chicago, Illinois 60610

Zoonoses in the Southeastern United States and Caribbean, Feb. 12-13, Florida Division of Health, Jacksonville. For information: Gerald L. Hoff, Ph.D., P.O. Box 210, Jacksonville 32201

Bacteremic Shock, Feb. 18, Martin Memorial Hospital Trailer Conference Room, Stuart*

First Annual Cancer Symposium, Feb. 19-22, Walt Disney World, Orlando. For information: Martha Bonar, 134 E. Colonial Dr., Orlando 32801

Courses of Instruction in Coronary Care, Feb. 17-22, Jackson Memorial Hospital, Miami*

Medical and Surgical Approach to Cerebrovascular Problems, Feb. 21-22, Hilton Hotel, Gainesville**

Pediatric Behavior Management Conference, Feb. 21-22, Department of Pediatrics, University of Miami School of Medicine, Miami*

The Diagnosis and Treatment of Acute and Chronic Respiratory Failure, Feb. 24-28, Miami Beach*

Thromboembolism: Diagnosis and Treatment, Feb. 27-Mar. 1, Doral Hotel, Miami Beach*

Skin—1975: Modern Management of Common Skin Disorders, Feb. 27-Mar. 2, Miami*

AMA/FMA Financial Management Seminar, Feb. 27-Mar. 2, Amelia Island Plantation, Amelia Island. For information: A. J. Facca, Management Services Dept., AMA, 535 N. Dearborn St., Chicago, Illinois 60610

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

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Contraindications: hypersensitivity to barbiturates or belladonna alkaloids; glaucoma, prostatic hypertrophy, pyloric obstruction. **Side Effects:** dry mouth, blurred vision, dysuria, skin rash, constipation or drowsiness. **Dosage:** one or two tablets preferably before meals and at bedtime.

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ORTHOPEDIC SURGEON: Surgical group in central Florida is seeking a board certified orthopedic surgeon. Expanding town equally distant from hoth coasts, 100-bed hospital. Send curriculum, vitae. Write C-663, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST AND INTERNIST needed in a medical center located in central Florida. New offices availahle adjacent to a nondenominational community hospital. Reply to: P. O. Box 268, Medical Center, Sebring, Florida 33870.

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situations wanted

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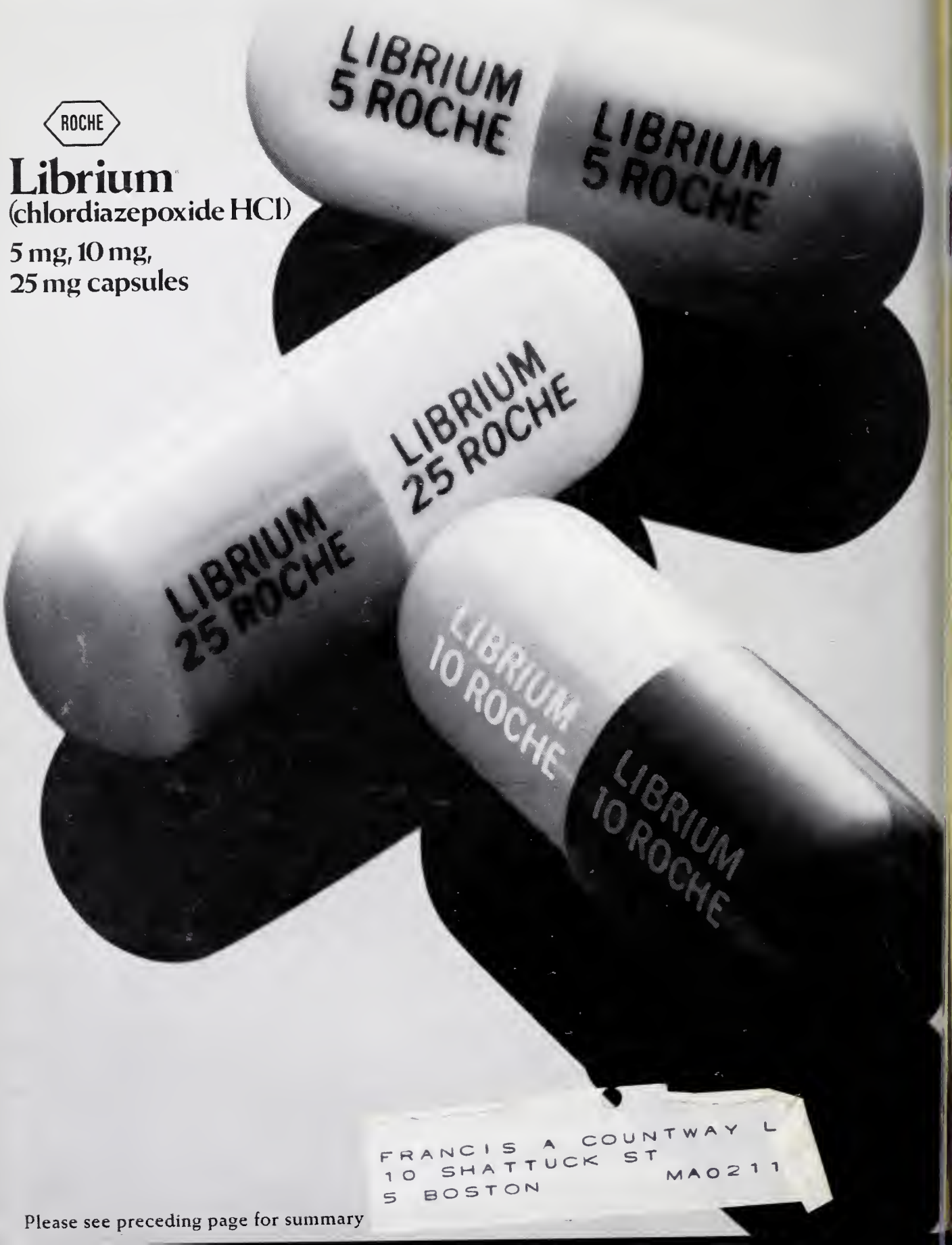

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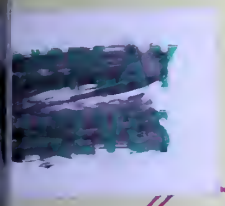

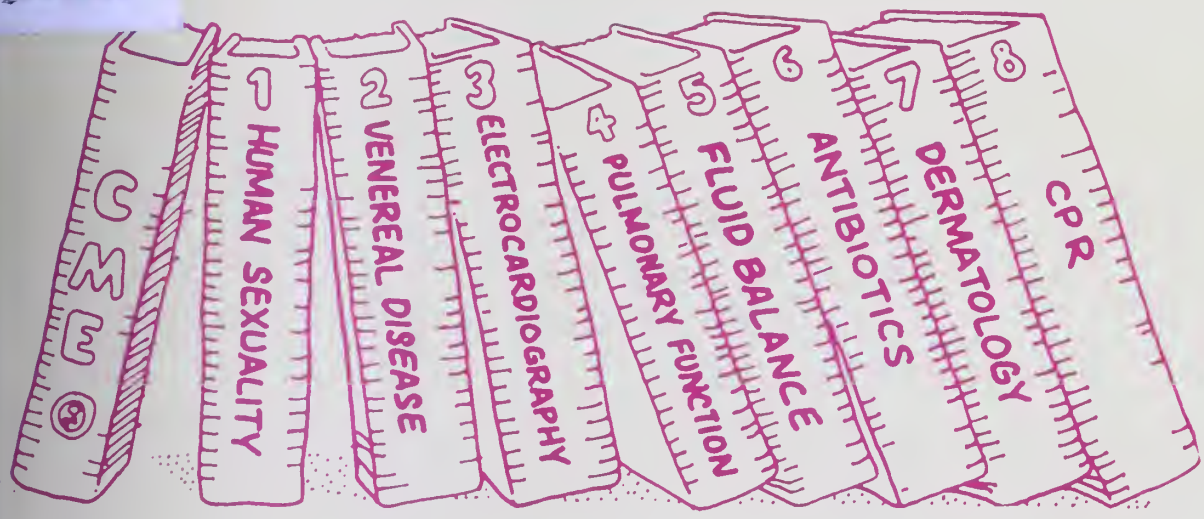

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Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

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with associated
depressive symptoms

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t possible hazard.

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ts severely depressed, or with latent
sion, or with suicidal tendencies.
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Truth in Gentle Terms

I have been aggravated by unreasonable patients;
yet encouraged by their consideration
and comforted by their understanding.
I have come to realize that patients are people
with hopes and enthusiasm,
goals and aspirations
and a suspicion of the new and unknown;
with an innate desire to be kind
but fear of being rebuffed;
with a skeptical opinion of others
and, therefore, a reluctance to express their feelings.
I have come to understand, in a limited way,
people acquainted with fear and defeat,
whose angers and frustrations
color their relationships;
people under the stress of an unfamiliar episode
called "being ill"
which brings to the surface their stored emotions;
people who need understanding and consideration
and the truth in gentle terms,
the physician who understands their problems
and earns confidence with the sureness of his actions.
We physicians are also people —
aware of fear and defeat,
the feelings of anger, frustration,
and helplessness, the often shattering reality
that human ability is not enough.
Knowing our own limitations,
the next time we would judge a patient,
let's pause for just the moment needed
and think of ourselves in the same situation.
Would we do so well?

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...igated Estrogens Tablets, U.S.P.)

...cations: Based on a review of ...MARIN Tablets by the National Acad... of Sciences-National Research Council ...or other information, FDA has classified ...ndications for use as follows:
...tive: As replacement therapy for nat... occurring or surgically induced estro... deficiency states associated with: the cli...eric, including the menopausal syndrome ... postmenopause; senile vaginitis and ...rosis vulvae, with or without pruritus.
...obably" effective: For estrogen defi...cy-induced osteoporosis, and only when ... in conjunction with other important ...apeutic measures such as diet, calcium, ...iotherapy, and good general health-...noting measures. Final classification of ...indication requires further investigation.

...indications: Short acting estrogens are ...indicated in patients with (1) markedly ...red liver function; (2) known or suspected ...oma of the breast, except those cases of ...ssing disease not amenable to surgery or ...ation occurring in women who are at least ...s postmenopausal; (3) known or suspected ...en-dependent neoplasia, such as carci... of the endometrium; (4) thromboembolic ...ers, thrombophlebitis, cerebral embolism, ...patients with a past history of these condi... (5) undiagnosed abnormal genital bleeding.
...ings: Estrogen therapy should not be given ...men with recurrent chronic mastitis or ab... mammograms except, if in the opinion of ...ysician, it is warranted despite the possibil... aggravation of the mastitis or stimulation ...diagnosed estrogen-dependent neoplasia.
...e physician should be alert to the earliest ...festations of thrombotic disorders (throm...ebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®
...AND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

anavac

The gentle evacuant that cleans the bowel and diverticuli.

Anavac Tablets contain:
Sodium Lauryl Sulfate...25 Mg.
1,8 Dihydroxyanthraquinone .....75 Mg.

Action and Uses: Anavac is a gentle evacuant that cleans the bowel and reduces the lytic or digestant action when it comes in contact with the anal skin. The sodium lauryl sulfate seems to gently cleanse the diverticuli by detergent properties. Anavac improves the muscle tone of the flaccid large bowel by gentle peristalic stimulation...accomplished (through the blood stream) by impulses at the Meissner Plexus of the colon. Since the Danthron bypasses most of the small bowel, there is no interference with digestion or fat-soluble vitamin absorption. Anavac is non-cumulative and non-toxic. The sodium lauryl sulfate seems to reduce the overstimulating effects of Danthron.

Administration and Dosage: Adults: one or two tablets after the evening meal with a full glass of water. Children under 12: one-half tablet with fluid after evening meal.

Side Effects: May produce a discoloration of the urine. This is of no clinical significance. May appear in milk of lactating mothers.

Precautions: Frequent or prolonged use may result in dependence on laxatives.

Contraindications: Should not be used when nausea, vomiting, abdominal pain or other symptoms of appendicitis are present.

How Supplied: Bottles of 100 and 1000 orange, coated tablets.

For a free clinical supply and literature:
call or write:
Dr. E. Petry, M.D.
8906 Rosehill Road
Lenexa, Kansas 66215
(913) 888-8168

DOUGLAS PHARMACAL INDUSTRIES, INC.
DISTRIBUTOR

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml.

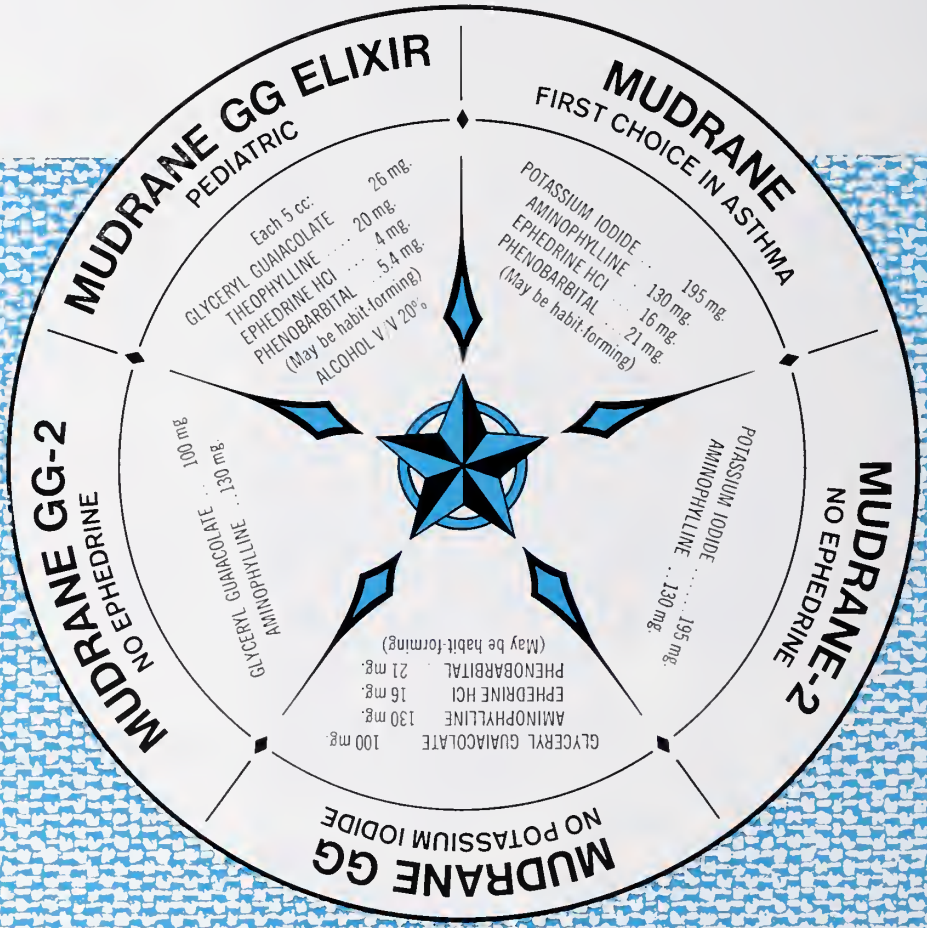
ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

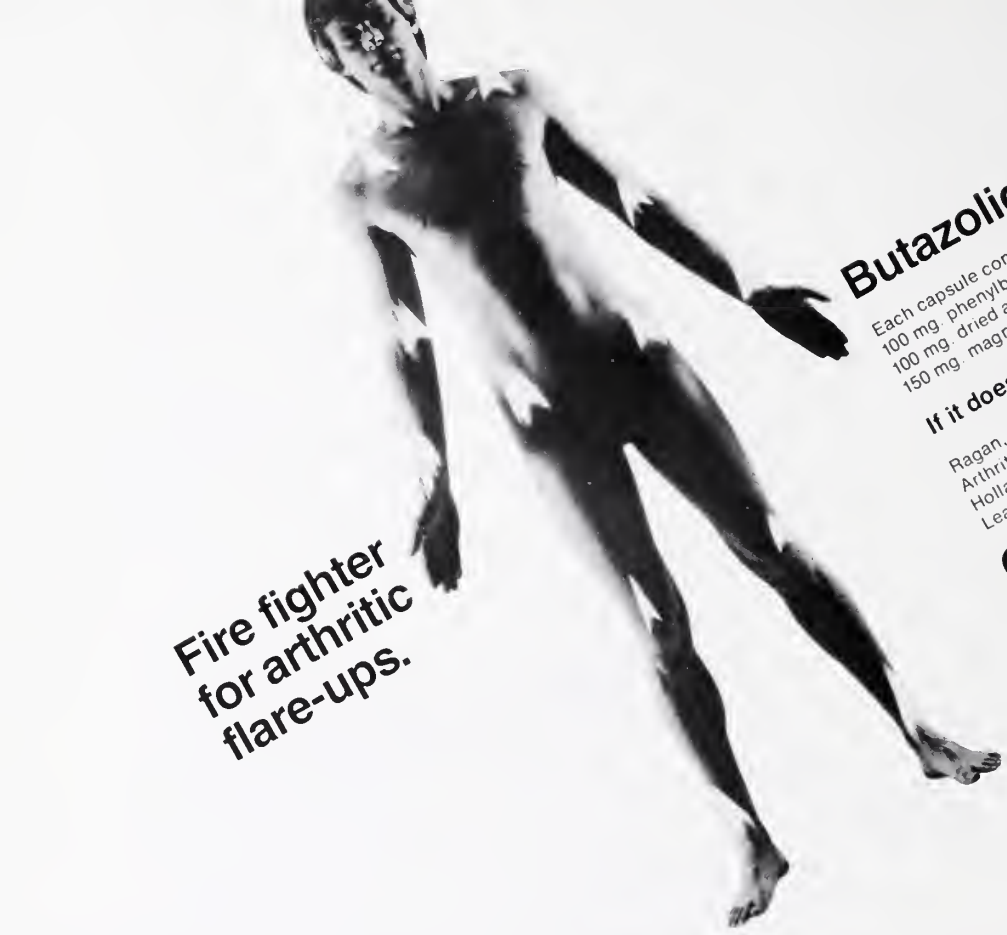
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy, blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty discontinue drug.
Precautions. The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesteremic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if the dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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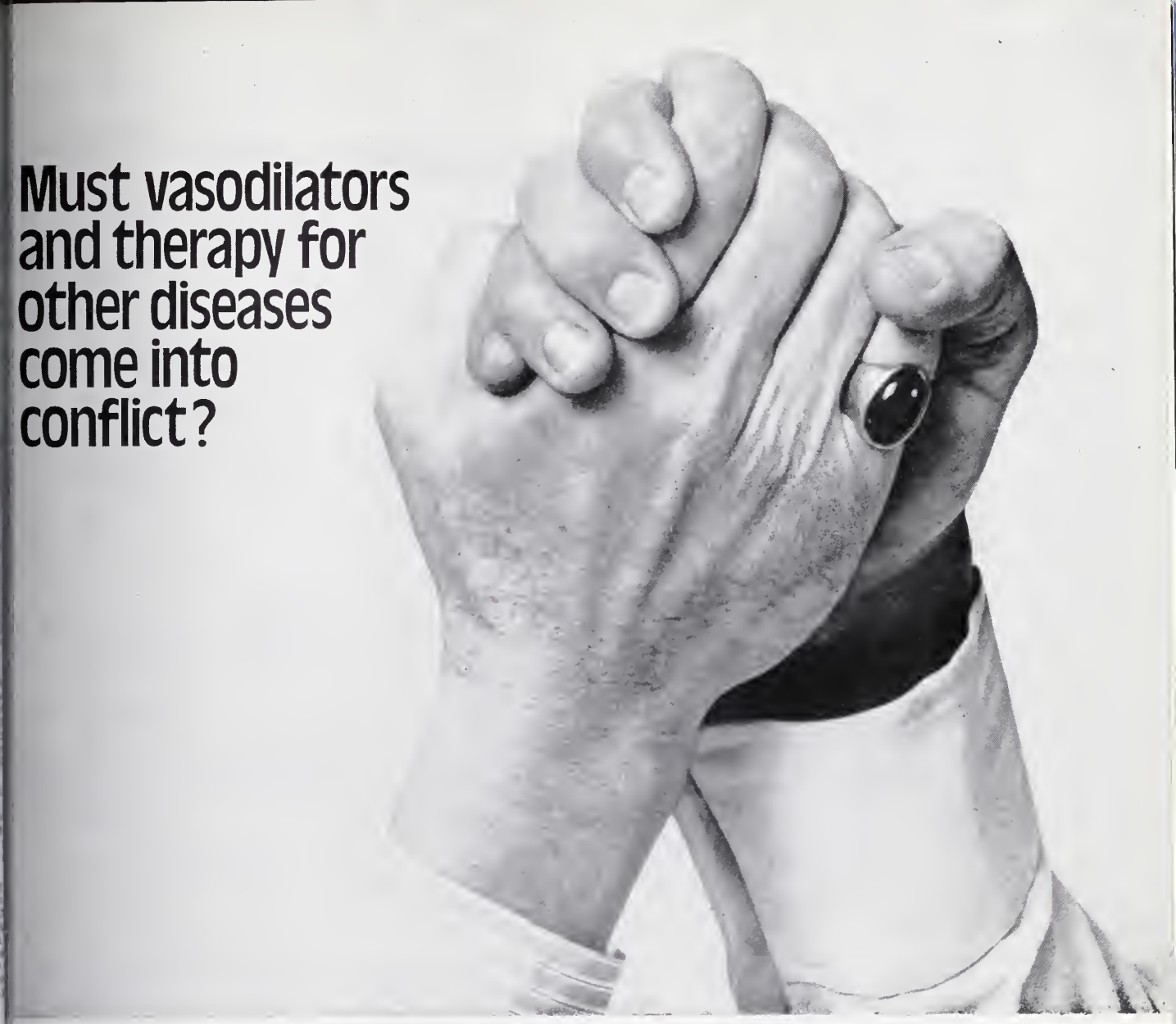
Must vasodilators and therapy for other diseases come into conflict?



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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

FEBRUARY

Seminar Session, Department of Anesthesiology, Mar. 3-7, University of Florida College of Medicine, Gainesville**

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 3-8, Americana Hotel, Miami Beach*

Current Topics in Endocrinology (CPC), Feb. 7, A. Vance Morgan Education Center, South Miami Hospital, Miami

Regional Postgraduate Courses by Council on Scientific Assembly, Feb. 8-9, Admiral Benbow Inn and Host Airport Hotel, Tampa. For information: Ms. Alice Harvey, Asst. Postgraduate Course Director, 535 North Dearborn St., Chicago, Illinois 60610

Zoonoses in the Southeastern United States and Caribbean, Feb. 12-13, Florida Division of Health, Jacksonville. For information: Gerald L. Hoff, Ph.D., P.O. Box 210, Jacksonville 32201

Bacteremic Shock, Feb. 18, Martin Memorial Hospital Trailer Conference Room, Stuart*

First Annual Cancer Symposium, Feb. 19-22, Walt Disney World, Orlando. For information: Martha Bonar, 134 E. Colonial Dr., Orlando 32801

Courses of Instruction in Coronary Care, Feb. 17-22, Jackson Memorial Hospital, Miami*

Stroke: A Comprehensive Review of Recent Trends, Feb. 21-22, Hilton Hotel, Gainesville**

Pediatric Behavior Management Conference, Feb. 21-22, Department of Pediatrics, University of Miami School of Medicine, Miami*

The Diagnosis and Treatment of Acute and Chronic Respiratory Failure, Feb. 24-28, Miami Beach*

Thromboembolism: Diagnosis and Treatment, Feb. 27-Mar. 1, Doral Hotel, Miami Beach*

Skin—1975: Modern Management of Common Skin Disorders, Feb. 27-Mar. 2, Miami*

AMA/FMA Financial Management Seminar, Feb. 27-Mar. 2, Amelia Island Plantation, Amelia Island. For information: A. J. Facca, Management Services Dept., AMA, 535 N. Dearborn St., Chicago, Illinois 60610

MARCH

▸ Continuing Education in Contemporary Medicine and Surgery, Mar. 2-7, Americana Hotel, Miami Beach. For information: American Soc. of Contemporary Medicine & Surgery, 40 N. Michigan Ave., Chicago 60602

3rd Annual Postgraduate Seminar in Emergency Medicine, March 5-9, Hyatt House, Miami Beach. For information: John Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Marco Island Cardiology Seminar, Mar. 2-4, Marco Beach Hotel, Marco Beach. For information: J. A. Hinckley, Box 11083, Richmond, Va. 23230

Updating the Management of Leukemias or Lymphomas, Mar. 6, Biscayne Medical Center*

Urology—Selected Topics for the Practitioner, Mar. 6-8, Hilton Inn, Gainesville**

Third Annual Postgraduate Seminar in Emergency Medicine, Mar. 6-9, Hyatt House, Miami Beach. For information: John F. Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Postgraduate Seminar in Neurology, March 10-14, Fontainebleau Hotel, Miami Beach*

Hormones and Cancer, March 10-14, Americana Hotel, Miami Beach*

Hypertension, Diabetes and Hyperlipidemia in Childhood, March 11-14, Americana Hotel, Miami Beach*

Cardiovascular Investigations With Radionuclides, Mar. 12-16, Miami Beach Hyatt House**

Pediatric Surgical Postgraduate Course, Mar. 13-14, Variety Children's Hospital, Miami. For information: W. T. Brown, M.D., 6125 S.W. 31st St., Miami 33155

"Nephrology and Hypertension," Mar. 15-16, St. Vincent's Medical Center, Schultz Auditorium, Jacksonville

Clinical Radiology Seminar, March 18-22, Hyatt House, Miami Beach*

Systemic Metabolic and Hormonal Effects of Cancer, Mar. 18, Hospital Trailer, Martin Memorial Hospital, Stuart*

Seventh Teaching Conference in Clinical Cardiology, March 19-22, Sheraton Four Ambassadors Hotel, Miami*

Topics in Internal Medicine, Mar. 20-22, Gainesville Hilton, Gainesville**

Hematologic Complications of Cancer and Allied Diseases, Mar. 21, Auditorium, Parkway General Hospital, N. Miami Beach*

Obstetric & Pediatric Anesthesia Seminar, Mar. 21-23, Diplomat Hotel, Hollywood. For information: Frank Moya, M.D., Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Eighth Annual Instructional Course in Surgery of the Hand, March 21-23, University Hospital, Jacksonville. For information: Ira M. Dushoff, M.D., 824 Margaret St., Jacksonville 32204

Hypertension, Diuretics and Renal Disease, March 24-25, Sheraton Four Ambassadors Hotel, Miami*

Radiation Oncology: Indications for and Treatment of Cancer Patients, Mar. 27, Assembly Room, Florida Hospital, Orlando*

APRIL

Clinical Cardiology for the Practitioner, Apr. 3-4, Hilton Inn, Gainesville**

Seminar Session, Department of Anesthesiology, Apr. 7-11, University of Florida College of Medicine, Gainesville**

Fracture Bracing Workshop, Apr. 12-13, Miami*

Courses of Instruction in Coronary Care, Apr. 14-19, Jackson Memorial Hospital, Miami*

▸ Geriatric Medicine 1975, Apr. 16-17, Sutton Beach Hotel, Miami. For information: American Geriatrics Soc., 10 Columbus Circle, New York 10019

15th Workshop in Electrocardiography, Apr. 24-28, Tides Hotel, Redington Beach St. Petersburg. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Program for Foreign Medical Graduation, Apr. 28 & July 24, Sheraton Four Ambassadors Hotel, Miami Beach*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▸ National meetings being held in Florida.

The overweight diabetic...

trapped by her own fat cells.

Only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower her blood sugar is a drug that stimulates more insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

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phenformin HCl

Lowers blood sugar without raising blood insulin.

DBI® phenformin HCl Tablets of 25 mg.
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Capsules of 50 and 100 mg.

Indications: Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

Contraindications: Diabetes mellitus that can be regulated by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; a history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; cardiovascular collapse (shock); after disease states associated with hypoxemia.

Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, hypotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.

b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake. *"Destabilization" of Previously Controlled Diabetic:* When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B) 98-146-103-G (8/74)

For complete details, including dosage, please see full prescribing information.

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DBI 10450

The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology

X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE

Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

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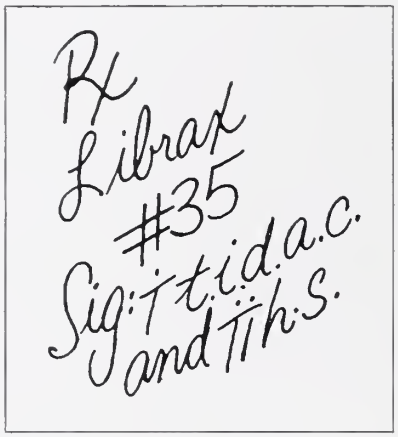
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Initial therapy

The initial prescription allows evaluation of patient response to therapy.

Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan™)—bottles of 100 and 500.

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SUSTAINED RELEASE THROUGH MICRO-DIALYSIS DIFFUSION... AN IMPROVED DELIVERY SYSTEM

New ISO-BID can help to reduce the frequency and intensity of angina attacks through microdialysis diffusion (controlled sustained release).

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate for up to 12 hours at a smooth, continuous, predictable, *controlled* rate. *Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables.* ISO-BID is particularly advantageous in the prevention of nocturnal angina.

Prescribe ISO-BID. There is nothing else just like it... because MICRO-DIALYSIS DIFFUSION MAKES THE DIFFERENCE.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Not intended for sublingual use. Supplied in bottles of 30, 100 and 500 ISO-BID capsules.

Consult product brochure before prescribing.

ICATIONS: Based on a review of this drug by National Academy of Sciences — National Research Council and or other information, FDA has ssified the indications as follows:

ssibly" effective: For the relief of angina toris (pain of coronary artery disease). ISO-BID ot intended to abort the acute anginal episode, is widely regarded as useful in the prophytic treatment of angina pectoris. Final classifiion of the less-than-effective indication requires ther investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and or exfoliative dermatitis is occasionally seen.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

FEBRUARY, 1975 • VOLUME 62 • NUMBER 2

Cocaine Intoxication

A Unique Case

CHARLES MEBANE, M.D.,
AND JAMES J. DEVITO, M.D.

Abstract: An unusual case is presented of cocaine intoxication in a 19-year-old girl resulting from an attempt to ensure a supply of the drug for her private use. Two "fingercot balloons" were swallowed, 3 cm x 3/4 cm, filled with 2 Gm of pure cocaine each. When one of the balloons ruptured, fulminating toxic symptoms manifested by Grand Mal type convulsions and respiratory arrest occurred which were treated with pentobarbital. The response was good and the "balloons" were recovered by purging the patient with castor oil. There was a prolonged period of some confusion, disorientation and hesitant speech following the episode but eventual full recovery of the sensorium. It is believed that all physicians should be alerted and made aware of the many methods of obtaining narcotic drugs because of the serious consequences of this case.

Practicing physicians must continuously review the drug abuse problem since patterns of addiction change. It is becoming more important for them to be cognizant of the various signs and symptoms presented by intoxicated patients. One well-known abused drug is cocaine and the number of patients are increasing who require treatment for toxicity. This should warn physicians to remain vigilant and familiar with measures which may be needed to save life.

Cocaine is obtained from the leaves of Erythroxylon coca and other species of Erythroxylon indigenous to Peru and Bolivia.[1] For centuries the natives used it to increase endurance by stimulating the central nervous system. The average lethal dose is about 1.2 Gm but fatalities due to idiosyncrasy have occurred from as little as 20 mg.[2] Cocaine's effects are due to direct stimulation of the cerebral cortex and midbrain as well as the sympathomimetic influence.

This is the report of acute toxicity in a patient caused by cocaine ingested in a rather unusual manner.

Report of Case

The rescue squad brought the patient, a 19-year-old white girl, to the Satellite Unit in St. Augustine. She had suffered acute respiratory arrest with convulsive seizures at home and had been resuscitated by her mother. The rescue team administered cardiac pulmonary resuscitation measures before arrival at the emergency room.

A member of the patient's family reported that she had eaten spoiled food during a recent trip to Bogota, Colombia. The remaining history was unremarkable except for repeated upper respiratory tract infections.

Upon admission to the hospital, the girl was semicomatose, exhibited generalized tremors and was startled by sudden movements or sounds. Her face was flushed and had an anxious expression. The pupils were widely dilated and fixed. The chest was clear to ausculation and percussion. The heart rate was 110 per minute. Tenderness was present in the mid-epigastric region. Neurological evaluation was difficult due to the hyper-reactive state.

Dr. Mebane is a resident physician, Family Practice Program, St. Vincent's Hospital, Jacksonville and Dr. DeVito is Associate Director, Family Practice Program, St. Vincent's Hospital, Jacksonville.
From Department of Family Medicine, University of Florida College of Medicine, Gainesville.

The patient was placed in the intensive care unit and generalized clonic and tonic seizures continued with foaming at the mouth.

The complete blood count revealed hemoglobin 12 Gm%, hematocrit 36%, white blood cells 21,000 with 90% segmented neutrophiles, 5% lymphocytes and 5% monocytes. Toxic granulations were present on peripheral smear. Urinalysis revealed specific gravity of 1.005 with 20-25 white blood cells per high power field and 1+ bacteria. The blood chemistry was within normal limits. EEG revealed essentially normal brain waves with changes consistent with medication effects.

The seizures persisted over a 24-hour period. During lucid moments she revealed intake of cocaine by "balloon" while in Bogota. In view of this additional history, intravenous pentobarbital was initiated. No further seizures were noted and the level of consciousness improved to the point where she could be aroused when called by name.

A nasogastric tube was introduced and she was gavaged with juices and other liquids, also castor oil, which resulted in bowel movements. Initial passage revealed some form of corn or maize. Subsequently two small pledgets passed which resembled balloons 3 cm in length and approximately ¾ cm in diameter, one end being doubled and the other knotted.

Additional history revealed that the patient had swallowed two fingercots filled with 2 Gm of pure cocaine each. Analysis of expelled materials showed that one had ruptured.

The patient progressed well through the remaining hospital stay. There appeared to be no residual effects from the cocaine intoxication.

Discussion

Several authors have presented systematic findings regarding acute cocaine intoxication.[2-4] The principal manifestations are convulsions and circulatory failure. Cocaine stimulates the central nervous system from above downward; initially cortical irritability is manifested by restlessness and excitement. Stimulation of lower motor centers caused tremors and convulsive movements. Cord reflexes are increased and clonic-tonic convulsions appear. Respiratory failure and death, which also may eventuate, result from depression of vital medullary centers.

References

1. Osol, A.: The Dispensatory of the United States of America, 1955, J. B. Lippincott Co., pp. 338-342.
2. Goodman, J. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 4th ed., 1970, Macmillan Company, pp. 379-382.
3. Arena, J. A.: Poisoning Chemistry—Symptoms-Treatment, 1963, Charles C. Thomas, pp. 202-203.
4. Grollman, A. and Grollman E.: Pharmacology and Therapeutics, 7th ed., 1970, pp. 403-408.

▶ Dr. DeVito, P. O. Box 1437, St. Augustine

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
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Further Consideration of Uncomplicated Urinary Infections

Frank M. Woods, M.D.

Abstract: In treating urinary infections, the clinician must give foremost consideration to the patient and use the bacteriology laboratory for assistance. Many infections are eradicted by an antibacterial or an antibiotic which the in vitro sensitivity test later reports as resistant. Also agents reported as treatment of choice may fail. The clinical response is the most effective test of therapeutic agents.

Up until 1935, the treatment for urinary infections left much to be desired. Changes in the pH using potassium acetate, nitrate and bicarbonate, and soothing preparations of tincture of opium, hyoscyamus and belladonna along with copaiba, sandalwood oil and buchu were commonly used. Hexamethylenamine which formed formalin in an acid urine was effective in some uncomplicated infections. Then came the ketogenic diet and acidifying drugs such as mandelic acid.

In the mid-30's the sulfonamides appeared. These produced dramatic results in instances but also some complications of hematologic nature, not to mention complete urinary obstruction from crystalluria.

Antibiotics in the early 40's added a new dimension that gave startling results even though homeopathic doses were used in the beginning.

Then came the sophisticated superscientific approach of culture and sensitivity studies using antibacterial and antibiotic agents in the culture dishes. Since 1945 this has been done on an enormous scale throughout the world. The result of these tests are represented to indicate the choice of antibacterial agents. Some 15 years ago Cocco and Smith stated that "a degree of fortitude or folly or of both is required of the clinician who prescribes a drug that has been reported by the laboratory to be ineffective."[1]

Many medical students during the past 20 years are prone to treat the laboratory instead of the patient. One cannot be dogmatic and need not wait 48 hours for the report before instituting therapy. He also need not change his therapy if he obtains a favorable clinical response to his primary therapy while awaiting the bacteriological report. This includes disappearance of symptoms, return of urinalysis to normal and a negative culture after treatment.

Clinicians are inclined to forget that the blood and lymph contain certain chemical substances of a complex nature, antitoxins, lysins and other antibodies which are the basis of the body's defense against injurious agents of various kinds. Phagocytosis must not be overlooked. Elevated temperature is a host factor that used to be induced or encouraged to a degree to combat infection. Perhaps autoimmunology is enhanced by elevated temperatures. Fever in patients may be the result of infection or other causes. Many patients have become entirely normal without benefit of any medication, and this factor must be borne in mind when we attribute cures to various drugs.

Dr. William Eudy recently reported on 662 cases providing sufficient data correlating in vitro sensitivity and therapeutic results for statistical analysis.[4] He presented comparisons of sensitive cures, sensitive failures, resistant cures and resistant failures. He concluded that the clinical response constituted the most effective test of therapeutic agents. He further concluded that there was no correlation between the in vitro sensitivity and therapeutic response in urinary tract infections.

It has been documented many times as to the action of antibacterials and antibiotics on

bacteria such as actual disruption of the cell wall, the effect on protein synthesis and the substitution of certain essential elements required by bacteria. It has further been brought up that some antibiotics are bacteriocidal, whereas others are bacteriostatic. It has further been pointed out that certain antibiotics and antibacterials are nephrotoxic and that with kidney disease the serum levels of these antibiotics are elevated. With this in mind and the advent of prescribing strictly generic names with substitution by pharmacists we must consider the possibility of serum level determination during treatment.

In spite of the in vitro and in vivo correlations relative to sensitivity testing and therapeutic response it has long been known that there are certain antimicrobial drugs of choice when one is cognizant of the offending organism such as penicillin for the gram-positive and gram-negative cocci, chloramphenicol for salmonella, gentamicin for Enterobacter (Aerobacter) and various others. Since urinary infections are treated either specifically or incidentally as complications by all doctors one must keep in mind that patients are people and not petri dishes and the clinical response is of prime importance.

▶ Dr. Woods, 550 Brickell Avenue, Miami 33131

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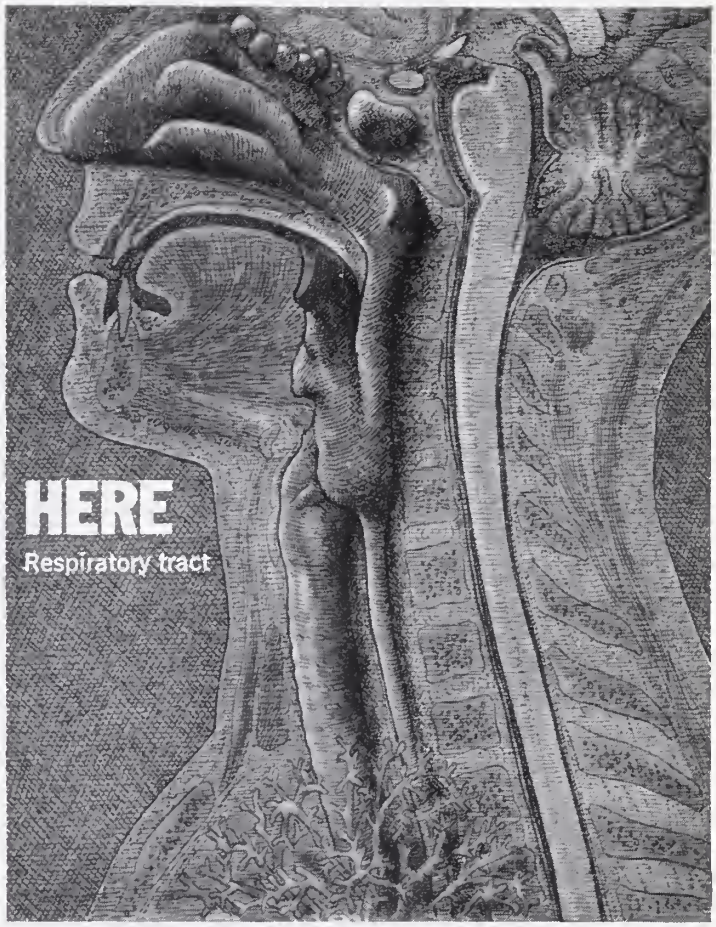

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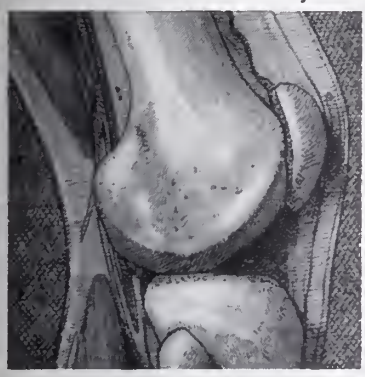

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Editorial

More Action on the Professional Liability Front

Encouraging and timely is the editorial, "Actions on the Professional Liability Front" (JFMA November 1974); its items ripple the devastating tide of malpractice lawsuits, astronomical judgments and skyrocketing insurance rates. Of greater importance, perhaps, and with far-reaching implications is a decision of the New Jersey Superior Court, Appellate Division, regarding rules adopted by the New Jersey Supreme Court governing contingency fee arrangements in tort (personal injury) litigation.

After 15 years of concern and deliberation the high court adopted a rule on December 19, 1971 effective January 31, 1972 regulating contingent fee arrangements in tort suits as follows: 50% on the first $1,000 recovered, 40% on the next $2,000, 33 1/3% on the next $47,000, 20% on the next $50,000, 10% on amounts over $100,000, and 25% on the first $50,000 if the recovery is a settlement without trial for an infant or incompetent. There is also a provision that an attorney could obtain a court hearing to request a higher fee if the limitations resulted in an inadequate fee.

As would be expected the American Trial Lawyers Association, New Jersey Branch, brought suit against the New Jersey Supreme Court to declare the rule unconstitutional. On an appeal from several rulings of the trial court, the Appellate Court reversed the trial court on February 14, 1974 declaring that the state constitution clearly gave the Supreme Court exclusive power to regulate the practice of law, including the power to adopt a reasonable rule governing permissible contingent fees in tort litigation, just as it had the authority to promulgate rules regulating bar examinations, licensing attorneys, adopting canons of ethics, creating a committee on the unauthorized practice of law, etc. It held the rule valid and constitutional and not discriminatory in applying only to contingent fees in negligence cases. To the argument that the fee limitations violated the attorneys' rights of freedom of contract, the court pointed out that attorneys have never had the right to enforce contractual provisions for more than a fair and reasonable fee. Membership in the bar was a privilege burdened with the conditions imposed by the court and derived from an attorney's position as an officer of the court.

Thus, the case of American Trial Lawyers Association, New Jersey Branch, vs New Jersey Supreme Court, 310 A. 2nd 19, could very well have produced a landmark decision. The trial lawyers, surely aware of its great significance, have not given up and the issue is now in the U.S. District Court for New Jersey.

If the federal court upholds the constitutional power of the state supreme court to adopt rules regulating contingent fees in tort litigation, great possibilities lie ahead. 1. The rule would apply to medical malpractice suits since these are included in tort actions. 2. Other states, Florida, for example, with an integrated bar where lawyers are officers of the court and part of the judiciary system could adopt similar rules relating to contingent fees in tort litigation. 3. This long sought after but elusive goal by physicians to place a limit on contingency fees in malpractice suits could now be accomplished by judicial decree rather than the legislative process (as suggested in the FMA legislative program). One has to be naive to entertain the hope that the state legislature packed with lawyers would pass legislation limiting attorneys' fees. 4. If such a rule limiting contingent fees in malpractice suits could be adopted by the Florida Supreme Court, the outlook on the professional front would be improved infinitely.

This interesting and unusual case is submitted to the attention of Florida Medical Association members so they may follow it closely and study its possibilities for implementation through the Florida Supreme Court.

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***IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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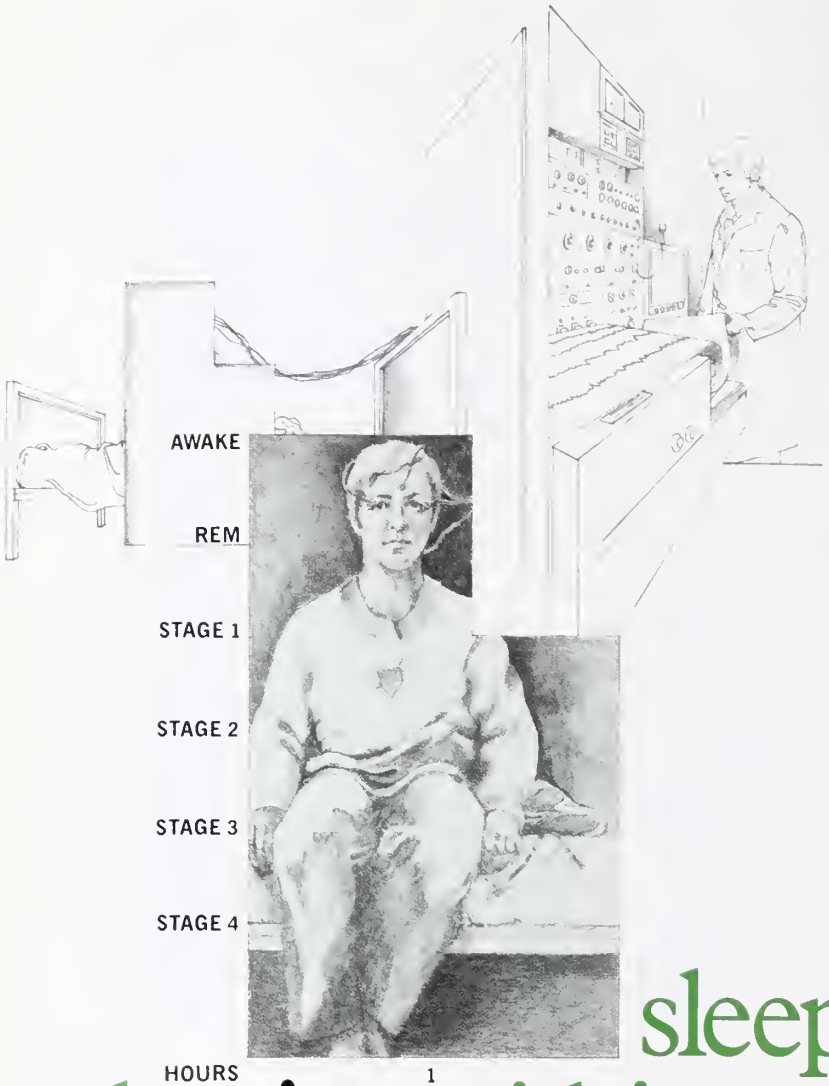

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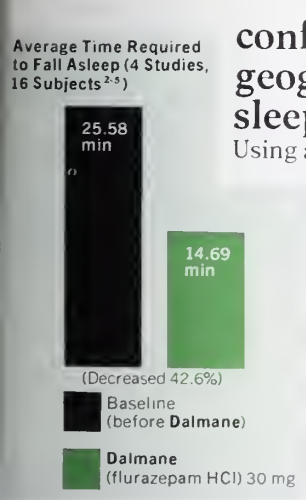

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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- induces sleep within 17 minutes, on average
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5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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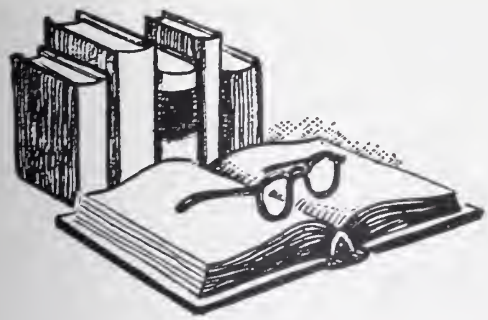

Book Reviews

Stress Disease, The Emotional Plague by Peter Blythe. 175 Pages. Price $5.95. New York, St. Martin's Press, 1973.

In Stress Disease: The Emotional Plague, Peter Blythe, a British psychotherapist and hypnotist, examines the problem and proposes some ways to reduce anxiety through "social engineering" and education. He quotes medical authorities as stating that nearly 70 percent of all sickness has its origin in unrelieved stress and anxiety such as heart disease, ulcers, asthma, diabetes, alcoholism, impotence and even death. Americans alone consume five billion pills a year to help them tranquilize their anxieties, to counteract depression, to help them sleep and to pep them up. Blythe feels that stress arises from a hidden, neurotic need for approval and an inability to make decisions. Psychotherapy, marriage counseling, hypnotism and group therapy are a few of the ways by which one can discover and treat these hidden needs. But before people will easily accept these methods, the medical profession must be taught to use them wisely and humanely.

Furthermore Blythe believes all schoolteachers should be trained in dynamic psychology so that they may understand the needs of their individual students. Each school must also have a counselor who acts as an intermediary between the scholars and the academic staff.

The teaching profession and big business should arrange courses in human communication. Their professional counselors must utilize group and individual techniques so that people can express their frustrations and be able to work out their problems in a suitable, accepting environment.

This is an interesting little book which delves into human psychology, medical science and case histories of stressful situations. It is well worth reading.

PERRY A. SPERBER, M.D., P.A.
DAYTONA BEACH

Gastrointestinal Disease—Pathophysiology, Diagnosis, Management, 1st ed. Edited by Marvin H. Sleisenger, M.D. and John S. Fordtran, M.D. 1,659 pages. 727 Illustrations. Price $37.50. Philadelphia, W. B. Saunders Company, 1973.

This excellent reference work on the gastrointestinal tract presents a physiological approach to the diagnosis and management of gastrointestinal disease. Fifty-seven contributors, including U. of Florida's expert on gastrin, James McGuigan helped to make this an outstanding volume. Careful editing as well as excellent illustrations including some beautiful color plates from endoscopy and microscopy enhance its value.

The editors chose not to include liver disease except as a complication of other primary gastrointestinal problems. The book can be recommended as a reference work.

F. NORMAN VICKERS, M.D.
PENSACOLA

Neonatology, Diseases of the Fetus and Infant edited by Richard E. Behrman, M.D. 698 Pages. 215 Illustrations. Price $39.50. St. Louis, The C. V. Mosby Company, 1973.

There are a number of excellent books dealing with disorders of the fetus and infant, including Pathology of Infancy and Childhood by Kissane and Smith; Diseases of Newborn by Schaffer; Blood Diseases of Infancy and Childhood by Smith, and of course the standard pathology reference book by Potter—Fetus and the Newborn. These books and others tend to probe deeply into etiologic factors, clinical recognition, and with the exception of the strict pathology volume, appropriate therapy of the disorders of the neonate. This volume under review, however, is a kind of synopsis. It covers all phases of the "disorders that have their onset in utero or during the neonatal period." The authors of the various sections, which include such areas as high risk infant, birth injuries, and disorders of the various organs and systems of the body, have achieved a readable writing style. Illustrations, including x-rays and charts and photographs are appropriate and well produced, and the subject matter is organized in a convenient style to provide ready reference. Especially helpful are a group of tables of normal values, commonly used drugs with appropriate dosages, and an excellent index. In the preface, the editor hopes that the book will serve pediatricians, obstetricians, family practitioners, nurses and special nursery assistants. This reviewer feels that it will do so and should be immediately available on the ward and in the nursery.

COURTLANDT D. BERRY, M.D.
NAPLES

Hallucinogens and Shamanism edited by Michael J. Harner. 200 pages. Price $1.95, New York, Oxford University Press, 1973. Paperback.

A Shaman may be defined as a man or woman who is in direct contact with the spirit world through a trance state and has one or more spirits at his command to carry out his bidding for good or evil. This book consists of chapters written by anthropologists or persons with anthropological interests who have observed shamanism in action. Shamanism exists mostly in primitive cultures and is frequently associated with the use of hallucinogenic materials.

An interesting chapter on the role of hallucinogenic plants in European witchcraft is written by the editor. He has some interesting theories that European witches rubbed their bodies with a hallucinogenic ointment containing atropine and henbane, whose content of atropine was absorbable through the skin.

This book will have limited appeal. However, references are included for those interested in deeper reading.

F. NORMAN VICKERS, M.D.
PENSACOLA

ORGANIZATION

Proceedings

Special Called Meeting

Florida Medical Association
House of Delegates

Tampa, December 21, 1974

The special called meeting of the House of Delegates was called to order at 10:20 a.m. on Saturday, December 21, 1974 at the Host Airport Inn, Tampa, Florida, by Dr. Louis C. Murray, Speaker.

The invocation was given by Dr. Jack Q. Cleveland, Past President, of Coral Gables.

The Speaker, Dr. Murray, announced the membership of the Credentials Committee.

Dr. Eugene G. Peek moved that the House of Delegates be called into Executive Session. The motion carried.

Dr. Donald G. Nikolaus, Chairman of the Credentials Committee, reported that 102 delegates were registered and 22 counties were represented. Dr. Nikolaus advised that this did not constitute a quorum which was 109 delegates and 23 component medical societies.

Dr. Louis E. Cimino of Hillsborough County moved that the delegates to the House sit as a reference committee to consider the items of business to come before the House until such time as a quorum was present. The motion carried.

The Speaker introduced the individuals at the Speaker's Table, Dr. Charles J. Kahn, Vice Speaker; Dr. Thad Moseley, President; Dr. Joseph C. Von Thron, Immediate Past President; Dr. Irving M. Essrig, Vice President; Dr. James W. Walker, Secretary-Treasurer; W. Harold Parham, D.H.A., Executive Vice President. Dr. Murray advised the House that Dr. Vernon B. Astler, President-Elect, was unable to be at the meeting due to illness.

Dr. Murray then presented Dr. Thad Moseley, President. Dr. Moseley thanked the delegates for attending the called meeting. He presented some of the background on the problems of PSRO and advised that three county medical societies, Dade, Duval and Hillsborough, had requested that a called meeting be held to reconsider FMA policy regarding PSRO. Dr. Moseley advised that, in accordance with the By-laws, the meeting was called and a thirty-day written notice was sent out to the delegates. Dr. Moseley also pointed out that the Board of Governors recommended to the House a dues increase to be considered at the next meeting of the House, whether special called meeting or regular meeting; therefore, the dues increase item was included in the agenda for this meeting.

Dr. Moseley urged that each member discuss the issues briefly, intelligently, and to limit debate. He requested that each vote be made intelligently and with discretion.

The Speaker, Dr. Murray, called for a current count of registered delegates and established that a quorum was still not present. A motion was made by Dr. Everett Shocket of Dade County to limit discussion on the agenda items to one hour and that if a quorum is not achieved by that time the Called Meeting of the House of Delegates is to be adjourned. The motion passed.

Dr. Murray, the Speaker, called for discussion on the three resolutions appearing in the packets.

Resolutions 74-CM-1, PSRO, Dade County Medical Association; 74-CM-2, PSRO, Hillsborough County Medical Association; and 74-CM-3, PSRO, Duval County Medical Society were presented by the respective county medical society sponsors. Dr. Rowland E. Wood of the Pinellas County Medical Society presented a substitute resolution on PSRO and each of the four resolutions were received as information since there was not a quorum present.

The Vice Speaker, Dr. Kahn, assumed the Chair and called for the presentation on the proposed dues increase. Dr. James W. Walker, Secretary-Treasurer of the Association, presented a detailed slide presentation on the finances of the

Association. Dr. Walker called attention to the recommendation of the Board of Governors for a dues increase that appeared in each packet and requested that when a quorum was established that the recommendation be adopted by the House. This was received as information.

Dr. Janice Sherwood of Dade County presented a resolution entitled, "Emergency Resolution on Professional Liability Insurance." This resolution was presented as information.

The House was advised that the Duval delegation was unable to leave Jacksonville by airplane and was enroute to Tampa by car. Dr. Sanford A. Mullen moved that the meeting be extended to allow the Duval delegation time to arrive. Motion carried to extend the meeting until 12:30 before it is adjourned for lack of a quorum.

The Speaker, upon request, asked representatives of the Dade, Duval, and Hillsborough County Medical Societies to meet as a committee and draw up a single resolution to replace 74-CM-1, 2, and 3. The committee left the House meeting to draw up the resolution.

Dr. T. Bryon Thames of Orange County moved that a straw vote be taken on the dues increase. The motion passed.

The House was advised that a quorum of delegates were now registered and a motion was made and passed to seat the delegates.

DELEGATES

ALACHUA—O. Frank Agee, Mark V. Barrow, William B. Deal. Gerold L. Schiebler (Absent—Henry J. Babers Jr., George H. Miller Jr.).
BAY—Philip Cotton (Absent—Owen Reese Jr.).
BREVARD—(Absent—Lewis A. Bean, John T. Blackburn, James E. Carter, T. John Kaminski, Robert C. Seelman).
BROWARD—(Absent—Robert J. Brennan, Andre S. Capi, R. B. Carson, M. P. Caster, Fred G. Gieseke, T. W. Hahn, James A. Jordan, William B. King, David C. Lane, George P. Messenger Jr., Jerry D. Moore, Ray E. Murphy, F. B. Ott, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Diran M. Seropian, N. J. Skaja, Daniel C. Smith, W. D. Wells).
CAPITAL—Nelson H. Kraeft, Jack W. MacDonald, Robert N. Webster (Absent—Robert P. Johnson).
CHARLOTTE—Melvyn I. Katzen, Charles Wilson.
CITRUS-HERNANDO—W. Randall Jenkins.
CLAY—Marcus B. Bergh.
COLLIER—(Absent—William J. Bailey, Fred A. Butler).
COLUMBIA—(Absent—B. L. Vanzant).
DADE—Jerome Benson, Richard C. Clay, Jack O. Cleveland, Vincent P. Corso, Joseph H. Davis, Richard C. Dever, J. Lee Dockery, Robert W. Elkins, Ivor Fix, R. L. Gerlaugh, Pedro J. Greer, Julian Groff, Joseph Harris, Walter C. Jones III, Robert B. Katims, Eugenia P. Lantz, Banning G. Lary, Lawrence Lefkowitz, Rose London, Donald Minervini, Frank Mova, Harold Norman, Ronald Scherr, Janice Sherwood, Everett Shocket, Mario M. Stone, William M. Straight, Charles F. Tate Jr., John C. Turner Jr., Edmund K. Zahn (Absent—Pedro Arroyo, William G. Aten Jr., Morris Blau, Manuel Carbonell, O. William Davenport, Charles A. Dunn, Franklin J. Evans, Joseph Fitzgerald, Marshall Hall, Henry C. Hardin, Walter C. Jones Jr., Carlos Llanes, Ronald Mann, Charles A. Monnin, Edwin P. Preston, Edward W. St. Mary, Robert J. Schiess, Daniel Seckinger, Ruth A. R. Simons, Chauncey M. Stone Jr., Robert E. Willner, Stanley I. Worton, Sheldon Zane).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, Clyde M. Collins, Wilbert L. Dawkins Sr., Joe C. Ebbinghouse, Walter G. Jarrell, Benjamin A. Johnson, John C. Kruse, Charles B. McIntosh, Faris S. Monsour, Thad Moseley, Sanford A. Mullen, Guy T. Selander, James W. Walker, William D. Walklett (Absent—John A. Rush).
ESCAMBIA—Charles J. Kahn, Theodore J. Marshall, Philip B. Phillips, William M. C. Wilhoit, Henry M. Yonge.
FRANKLIN-GULF—(Absent—Joseph P. Hendrix).
HIGHLANDS—Robert T. Rengarts.
HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Robert J. Courtney, Irving M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Victor H. Knight Jr., Joel W. Mattison, Thomas E. McKell, John K. Petrakis, Harold L. Williamson.
INDIAN RIVER—(Absent—James C. Robertson, Paul W. Taylor).
LAKE—Bergon F. Brokaw, Thomas D. Weaver.
LEE—John Fenning, Larry P. Garrett, F. Lee Howington.
MADISON—(Absent—William J. Bibb).
MANATEE—(Absent—John D. Lehman, Roger A. Meyer, M. P. Quillian).
MARION—H. L. Harrell, C. B. Henderson.
MARTIN—(Absent—John F. Powers).
MONROE—John Buckner (Absent—Ronald H. Chase).
NASSAU—(Absent—Marshall E. Groover).
OKALOOSA—William W. Thompson.
ORANGE—Francis M. Coy, William F. Eckbert Jr., Edward L. Farrar Jr., Clarence M. Gilbert, Joseph G. Matthews, Franklin B. McKechnie, Richard L. Parker Jr., James F. Richards Jr., Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo, Joseph J. Williams.
OSCEOLA—George A. Gant.
PALM BEACH—Willard P. Ande, Carl E. Andrews, Curtis W. Cannon, J. Russell Forlaw, Bernard Kimmel, C. E. Metzger, Richard B. Moore, R. J. Stambaugh, Dick L. Van Eldik, Harold A. Yount (Absent—George L. Ford Jr.).
PANHANDLE—(Absent—H. E. Brooks).
PASCO—(Absent—James P. Gills Jr.).
PINELLAS—Charles K. Donegan, Irwin L. Entel, James C. Fleming, John M. Hamilton, Walter W. Hamilton, Daniel S. Hellman, Roger A. Laughlin, Jack A. McCris, Donald G. Nikolaus, David T. Overbey, Richard C. Trump, Walter H. Winchester, Joseph Worth.
POLK—Marvin G. Burdette, Thomas M. Caswall, J. G. Converse, Howard M. DuBose, W. E. Manry Jr., Thomas E. McMicken, Paul A. Tanner Jr.
PUTNAM—M. Michaels
ST. JOHNS—(Absent—William W. O'Connell).
ST. LUCIE—(Absent—H. C. McDermid).
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Norman J. Gengler, Martin Mihm, Karl R. Rolls, Robert E. Windom.
SEMINOLE—Luis M. Perez.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Hugo F. Sotolongo).
TAYLOR—John H. Parker Jr.
VOLUSIA—O. B. Bonner Jr., James A. Carratt, William H. Harrison, Richard W. Snodgrass, Thomas L. Wells.
WALTON—(Absent—H. F. Currie).
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER OF THE HOUSE—Charles J. Kahn.

Dr. Thames then moved that the recommendation of the Board of Governors concerning the dues increase be adopted.

Dr. Bernard Kimmel of Palm Beach County Medical Society questioned the legality of the called meeting of the House since he believed the members did not receive the notice thirty days in advance. The President advised the House that a written notice had been sent out on the thirtieth day before the meeting and that he had consulted with legal counsel regarding this. The House of Delegates, by voice vote, concurred with the legality of this called meeting and were satisfied with the notice given in compliance with the Association's By-laws.

The motion to adopt the recommendation of the Board of Governors was seconded and the recommendation was adopted, to be effective January 1, 1975.

RECOMMENDATION NO. 1

The Board of Governors recommends adoption of the following By-laws amendments:

CHAPTER X—INCOME AND EXPENDITURES, Section 2, Dues Amend Section 2, paragraphs 1. and 2. to read:

1. Annual Dues.—Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be $125 PER YEAR FOR ACTIVE MEMBERS, $50 FOR ASSOCIATE MEMBERS, $25 FOR MEDICAL INTERNS AND FULL TIME PHYSICIANS IN AN APPROVED RESIDENCY OR INTERNSHIP, and $10 per year for student members. Included in all dues is an annual subscription to The Journal of the Florida Medical Association and one copy annually of the current Florida Medical Directory.

2. Entrance fee.—Each new active or associate member, except student members, shall be required to pay an entrance fee of $10 in addition to his annual dues.

MEDICAL STUDENT MEMBERS will pay a $10 entrance fee at such time as they are eligible for reclassification of membership.

(This increases dues for active members from $75 to $125 per year and associate members from $25 to $50 per year. It sets dues for interns and residents at $25 per year plus a $10 entrance fee.)

Dr. Sanford A. Mullen of Duval County, speaking for the designated committee to draw up a single resolution to replace 74-CM-1, 2, and 3, presented a substitute resolution for consideration by the House.

A motion was made and seconded to vote on the resolution on the floor. A standing count was taken and the motion failed for lack of a two-thirds vote. There was considerable discussion.

A motion was made by Dr. Daniel S. Hellman of Pinellas County to adopt a substitute resolution to replace the substitute resolution presented to replace 74-CM-1, 2, and 3. The motion was seconded, and the question was called for.

Dr. Joseph C. Von Thron moved that the vote be taken by secret ballot. This motion passed and the vote on the substitute resolution introduced by Pinellas passed by a vote of 72 to 68.

SUBSTITUTE RESOLUTION 74-CM-1

Substitute for the
Substitute for Resolutions 74-CM-1, 2, and 3

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

WHEREAS, the Florida Medical Association House of Delegates has encouraged its membership to exercise their option not to participate in PSRO, and has urged that Florida Medical Association members individually and collectively promote the repeal of Section 249 F, Public Law 92-603, and

WHEREAS, there may be some county medical societies in the State of Florida who wish to form PSRO's, and

WHEREAS, formation of PSRO's and participation in them is a matter of grave concern to a majority of physicians throughout the State of Florida, therefore, be it

RESOLVED, that no FMA component medical society may form a PSRO or actively participate in the formation of a PSRO in their respective area unless they have first taken a poll of their membership and have received more than 50% approval of the active and life membership of the County Medical Society for that participation, and be it further

RESOLVED, that any individual physician may participate fully in PSRO, but the Florida Medical Association reaffirms its encouragement to its membership to exercise their option not to participate in PSRO, and be it further

RESOLVED, that the Florida Medical Association reaffirms its unequivocal and emphatic rejection of the PSRO substitute for Peer Review, as outlined in Section 249 F, Public Law 92-603.

Dr. Janice Sherwood of Dade County called for a unanimous vote of the House to consider the emergency resolution on Professional Liability Insurance. Dr. Sherwood's request failed to receive a unanimous vote and the matter of professional liability insurance was not considered by the House.

The House was advised that 140 delegates were seated and 26 component county medical societies were represented.

The benediction was given by Dr. Jack Q. Cleveland and the House adjourned at 12:50 p.m.

FMA Annual Meeting

April 23-27, 1975

Annual Meeting Program To Feature 30 Scientific Sections

A comprehensive scientific program offering something of interest to virtually every physician and packaged into 30 scientific sections will be presented during the 101st Annual Meeting of the Florida Medical Association.

Scientific sessions will be conducted from Wednesday afternoon, April 23, to Saturday afternoon, April 26, at the Americana Hotel in Bal Harbour.

Program Chairman Yank D. Coble Jr., M.D., Jacksonville, pointed out that the physician who carefully plans his activities each day of the meeting can get credit for all 20 mandatory hours required on a pro rata basis for one year under the FMA's Continuing Medical Education Program. Programming was lengthened this year by adding scientific section hours on Wednesday afternoon and Thursday evening.

The Committee on Continuing Medical Education has applied to the American Academy of Family Physicians for accreditation of the complete program on an hour-for-hour basis. Attendance at the scientific sessions also will be acceptable for credit toward the American Medical Association's Physician Recognition Award.

FMA scientific programs are co-sponsored by the FMA and its approved specialty groups.

Dr. Coble said that inasmuch as professional liability is a matter of increasing concern to medicine, two programs are being arranged concerning that subject. An outstanding panel of attorneys and others is being put together for a general session on Thursday evening, April 24, from 5:30 to 7:00. In addition, the Florida Association of General Surgeons and the Florida Chapter, American College of Surgeons, will present a program entitled, "Update on Professional Liability" on Saturday morning, April 26.

Here is the day-to-day scientific program as it stood when this issue of *The Journal* went to press (consult future issues of *The Journal* for additional details):

WEDNESDAY, AFTERNOON — APRIL 23

SECTION ON INTERNAL MEDICINE

(Co-sponored by American College of Physicians and Florida Society of Internal Medicine)

Wednesday — 1:00 p.m. to 4:15 p.m.

Jay H. Sanders, M.D., Miami
Program Chairman

"Complex Acid-Base Disturbances," Laurence B. Gardner, M.D., Miami
"Medical Complications of Drug Abuse," Kenneth Schultz, M.D., Miami
(One other speaker to be announced).

THURSDAY AFTERNOON — APRIL 24

SECTION ON PSYCHIATRY

(Co-sponsored by the Council of Florida District Branches of the American Psychiatric Association)

Thursday—2:00 p.m. to 4:30 p.m.

Samuel I. Greenberg, M.D., Miami
Program Chairman

"The American Family — 1975"

"The Generation Gap Revisited," Carl H. Marlowe, M.D., Coral Gables
"Marriage: What's Right With It," Samuel I. Greenberg, M.D., Coral Gables
"The Family: New Roles, New Stresses," Meyer Maskin, M.D., Gainesville

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)

Thursday—2:00 p.m. to 5:00 p.m.

Roberto Llamas, M.D., Miami Beach
Eugene Sayfie, M.D., Miami
A. Jay Block, M.D., Gainesville
Eugene J. Linberg, M.D., Naples
Program Co-Chairmen

"The Adult Respiratory Distress Syndrome," Gordon Snyder, M.D., Professor of Medicine and Chief, Respiratory Disease Section, Boston University School of Medicine, Boston, Mass.

"The Adult Respiratory Distress Syndrome" (Panel)
Moderator: A. Jay Block, M.D., Associate Professor of Medicine and Anesthesiology, University of Florida College of Medicine, and Chief, Pulmonary Disease Section, Veterans Administration Hospital, Gainesville

Case Presentation: Michael F. Flick, M.D., Pulmonary Fellow, University of Florida College of Medicine, Gainesville

Panelists:
Gordon Synder, M.D., Boston, Mass.

Robert R. Kirby, M.D., Associate Professor of Anesthesiology and Surgery, and Co-Director of Respiratory Care, University of Florida College of Medicine, Gainesville

Allan L. Goldman, M.D., Assistant Professor of Medicine and Chief, Pulmonary Disease Section, University of South Florida College of Medicine and Veterans Administration Hospital, Tampa

Luis Martinez, M.D., Associate Professor of Radiology, University of Miami School of Medicine, and Associate Director of Radiology, Mount Sinai Hospital, Miami Beach

Leonard Smith, M.D., Instructor in Surgery, University of Miami School of Medicine, Miami

"Modern Non-Invasive Techniques in Cardiology," David Sheps, M.D., Assistant Professor of Medicine and Cardiology, and Director of the Exercise Laboratory, University of Miami School of Medicine, Miami

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)

Thursday—1:45 p.m. to 5:00 p.m.

David Wells, M.D., Miami
Program Chairman

"Solving Airway Management Problems," Robert R. Kirby, M.D., Associate Professor of Anesthesiology and Surgery, University of Florida College of Medicine, Gainesville

"New Directions in Emergency Medical Care," John S. Farquhar, M.D., Chairman, Department of Emergency Medicine, University Hospital, Jacksonville

"Emergency Treatment of Burns," Alan R. Dimick, M.D., Associate Professor of Surgery and Director of the Burn Service, University of Alabama, Birmingham

"MAST Trousers in the Treatment of Traumatic Shock," J. L. Lester III, M.D., Associate Professor of Surgery, Jackson Memorial Hospital, Miami

THURSDAY EVENING — APRIL 24

GENERAL SESSION ON PROFESSIONAL LIABILITY INSURANCE

(Co-sponsored by FMA Committee on Continuing Medical Education)

Thursday—5:30 p.m. to 7:00 p.m.

Moderator: Robert E. Zellner, M.D., Orlando, former Board Chairman, Blue Shield of Florida and former President, Florida Medical Association
(An outstanding panel, including prominent trial attorneys, will be announced)

FRIDAY MORNING — APRIL 25

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)

Friday—8:30 a.m. to 10:45 a.m.

Joel B. Mann, M.D., Miami
Program Chairman

"The Evaluation and Treatment of Hypertension" (Panel) (Panelists to be announced)

"Current Concepts in the Diagnosis and Management of Nephrolithiasis," Fredric L. Coe, M.D., Chairman, Nephrology Section, Michael Reese Hospital, Chicago, Ill.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Colon and

Friday—8:30 a.m. to 10:45 a.m.

Norman Gottlieb, M.D., Miami
Program Chairman

"Workshop in Rheumatic Diseases"

"Gout," John H. Talbott, M.D., Miami

"Rheumatoid Arthritis," Lawrence Shulman, M.D., Ph.D., Director of the Connective Tissue Division, Johns Hopkins University School of Medicine, Baltimore, Md.

"Osteoarthritis," David S. Howell, M.D., Fredie Gargano, M.D., Augusto Sarmiento, M.D., and Roy Altman, M.D., Miami

FRIDAY AFTERNOON — APRIL 25

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday—1:45 p.m. to 5:15 p.m.

Emmett F. Ferguson Jr., M.D., Jacksonville
Program Chairman

"Management of Fistula in Ano," Stanley Goldberg, M.D., Head, Department of Colon and Rectal Surgery, University of Minnesota School of Medicine, Minneapolis, Minn.

"Lower Urinary Tract Problems in Ano-Rectal Surgery," Walter W. Hamilton, M.D., St. Petersburg

"Lateral Internal Sphincterotomy," Shed Roberson, M.D., Daytona Beach

"Hemorrhoidal Surgical Techniques," Julian Suhrer, M.D., Head, Colon and Rectal Surgery, Memorial Hospital, Jacksonville

"Diverticular Disease — Current Surgical Management," Matthew Larkin, M.D., Head, Department of Colon and Rectal Surgery, University of Miami School of Medicine, Miami

"The Controversial Polyp," Ronald Rhatigan, M.D., Head, Department of Pathology, University Hospital, Jacksonville

"Choice of Operative Management of Carcinoma of Rectum," Stanley Goldberg, M.D., Minneapolis, Minn.

"Relief of Ano-Rectal Pain with Silastic Anesthetic Device," James Barron, M.D., Boca Raton

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Friday—2:00 p.m. to 5:00 p.m.

Elliott Podoll, M.D., Miami
Program Chairman

"The Child Who Won't Behave or Learn"

"The Dilemma of the Practicing Physician," Elliott Podoll, M.D., Associate Professor of Family Medicine and Pediatrics, University of Miami School of Medicine, Miami

"Management of the Hyperactive Clumsy Child Who Is An Underachiever," Ronald Cantwell, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami

"Role of the Educational Psychologist," Rebecca Carner, Ed.D., Dade County School Psychologist, Miami

SECTION ON PEDIATRICS AND SURGERY

(Co-sponsored by Florida Pediatric Society and Florida Association of Pediatric Surgeons)

Friday—2:00 p.m. to 5:00 p.m.

George A. Richard, M.D., Gainesville
James L. Talbert, M.D., Gainesville
Program Co-Chairmen

Moderator: James L. Talbert, M.D., Professor and Chief, Pediatric Surgery, University of Florida College of Medicine, Gainesville

"Inflammatory Bowel Disease," Adolfo D. Garnica, M.D., Assistant Professor, Division of Pediatric Genetics, Endocrinology and Metabolism, University of Florida College of Medicine, Gainesville

"New Diagnostic Techniques in Pediatric Gastroenterology," Bradley M. Rodgers, M.D., Assistant Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville

"Fluid and Electrolyte Management in Infants," Marc Rowe, M.D., Chief, Division of Pediatric Surgery, University of Miami School of Medicine, Miami

"Acid-Base Therapy in Newborns," John S. Currin, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa

"Infections of Chest," Robert M. McKey Jr., M.D., Associate Professor of Pediatrics and Director of the Cystic Fibrosis Center, University of Miami School of Medicine, Miami

"Laryngoscopy and Bronchoscopy in Infants and Children," William T. Brown, M.D., Chief of Surgery, Variety Children's Hospital, Miami

"Management of the Undescended Testicle," H. Warner Webb, M.D., Clinical Assistant Professor of Surgery, University of Florida College of Medicine, Jacksonville

SECTION ON ANESTHESIOLOGY AND EMERGENCY MEDICINE

(Co-sponsored by Florida Society of Anesthesiologists and Florida Chapter of the American College of Emergency Physicians in cooperation with Heart Association of Greater Miami)

Friday—1:45 p.m. to 5:30 p.m.

John C. Kruse, M.D., Jacksonville
Program Chairman

"Special Workshop for Physicians in Cardiopulmonary Resuscitation"

Registration and Pre-test
Welcome and Opening Remarks — John C. Kruse, M.D., Jacksonville

"Prescription for Life" (Movie)
"Recognition of the Life-Threatening Arrhythmias," Karen Craparo, M.D., Emergency Physician, Hialeah

"Life-Support Medication," Jere Creed, M.D., Emergency Physician, Hialeah
Practical Application of Cardiopulmonary Resuscitation Skills
Post-Test and Critique

SECTION ON ORTHOPEDICS AND RADIOLOGY

(Co-sponsored by Florida Orthopedic Society and Florida Radiological Society)

Friday—2:00 p.m. to 5:00 p.m.

Jaime M. Benavides, M.D., Key West
Program Chairman

"Fractures of the Cervical Spine," Donald Weir, M.D., St. Louis, Mo.

"Early Radiographic Signs of Prosthetic Failure," John J. Jennings, M.D., Assistant Professor, Department of Orthopedics and Rehabilitation, University of Miami School of Medicine, Miami

"Unusual and Subtle Fractures of Clinical Importance," Jaime M. Benavides, M.D., Key West

Panel Discussion
Moderator: J. Carlisle Hewitt, M.D., Tampa

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday—1:30 p.m. to 5:00 p.m.

Hueston C. King, M.D., Miami
Program Chairman

Welcome and Opening Remarks — George Singleton, M.D., Gainesville

Introduction of Program Theme and Speakers — Hueston C. King, M.D., Miami

"The Current Status of Cochlear Implants for Sensorineural Deafness," Antonio de la Cruz, M.D., Otologic Medical Group, Inc., Los Angeles, Calif.

"Transdermal Therapy for Speech Discrimination Improvement," Robert J. Harrison, Ph.D., University of Miami School of Medicine, Miami

"The RAST (Radioallergosorbent Test) — New Advance in Diagnosis of Allergy," N. Giorgio, M.D., R. Ali, M.D., and E. F. Schinagel, M.D., Pharmacia Laboratories, Inc., Pascataway, N.J.

"The Current Status of Silicone in Facial Surgery," Richard T. Farrior, M.D., and M. Brent Seagle, M.D., Tampa

"Artificial Larynx," Stanley Taub, M.D., New York, N.Y.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

Friday—4:00 p.m. to 5:30 p.m.

Daniel Seckinger, M.D., Miami
Program Chairman

"New Applications of Acid-Base Balance and Blood Gases," Harry F. Weisberg, M.D., Milwaukee, Wisc.

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic Surgeons)

Friday—2:00 p.m. to 4:00 p.m.

Thomas O. Gentsch, M.D., Miami
Program Chairman

"Experimental and Clinical Studies in Diaphragmatic Pacing," William W. L. Glenn, M.D., Charles W. Ohse, Professor of Surgery, Yale University School of Medicine, and Past President, American Heart Association, New Haven, Conn.

"Coronary Artery Surgery: Its Impact and Limitations in the Management of Ischemic Heart Disease" (Panel)

Moderator: William W. L. Glenn, M.D., New Haven, Conn.

Panelists:

Charles R. Conti, M.D., Professor of Medicine and Chief of Cardiology, University of Florida College of Medicine, Gainesville

Donald J. Fraser, M.D., Attending Cardiologist, Florida Hospital, Orlando

Parry B. Larsen, M.D., Attending Surgeon, Miami Heart Institute, Miami

SATURDAY MORNING — APRIL 26

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday—9:00 a.m. to 11:40 a.m.

David L. Lipkin, M.D., North Miami Beach
Program Chairman

"Electromyography: Uses and Abuses," Ariel Bar-Sela, M.D., Houston, Texas

"The Role of Bladder Training in the Evaluation of the Effect of a New Antispastic Drug," Matei Roussan, M.D., Bronx, N.Y.

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)

Saturday—9:00 a.m. to 12:00 noon

George A. Richard, M.D., Gainesville
Program Chairman

Moderator: Elia M. Ayoub, M.D., Professor and Chief, Division of Pediatric Infectious Disease and Immunology, University of Florida College of Medicine, Gainesville

"Immunologic Basis for Collagen-Vascular Disease," Rawle M. McIntosh, M.D., Associate Professor of Pediatrics and Clinical Immunology, and Chief, Pediatric Nephrology, University of Colorado Medical Center, Denver, Colo.

"Rheumatoid Arthritis, Dermatomyositis and Scleroderma," Jack H. Hutto, M.D., Fellow, Division of Pediatric Infectious Disease and Immunology, University of Florida College of Medicine, Gainesville

"Anaphylactoid Purpura, Acute Glomerulonephritis and Polyarteritis Nodosa," Jose Strauss, M.D., Director, Division of Pediatric Nephrology, University of Miami School of Medicine, Miami

"Rheumatic Fever," Louis E. Cimino, M.D., Associate Professor of Pediatric Cardiology, University of South Florida College of Medicine, Tampa

"Systemic Lupus Erythematosus," Eduardo H. Garin, M.D., Instructor, Division of Pediatric Nephrology, University of Florida College of Medicine, Gainesville

SECTION ON RADIOLOGY

(Co-sponsored by Florida Radiological Society)

Saturday—10:00 a.m. to 12:00 noon

J. Carlisle Hewitt, M.D., Tampa
Program Chairman

"Radiology of Joint Replacement," Tom W. Staple, M.D., St. Louis, Mo.

"The Application of Diagnostic Ultrasound in the Detection and Treatment of Malignancy," Don J. Brascho, M.D., Professor, Department of Radiation Oncology, University of Alabama Hospitals and Clinics, Birmingham, Ala.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)

Saturday—8:45 a.m. to 12:30 p.m.

R. Chris Brown, M.D., Largo
Program Chairman

"Symposium on Delivery of Health and Medical Care"

Welcome and Introduction of Speakers—R. Chris Brown, M.D., Largo, Moderator

"International Aspects of Health Care Delivery," Rafael A. Penalver, M.D., University of Miami School of Medicine, Miami

"The Health Officer and Health Department Services," C. L. Brumback, M.D., Director, Palm Beach County Health Department, West Palm Beach

"Group Practice and Its Role in Medical Care," Michael J. Pickering, M.D., Department of Nephrology, Watson Clinic, Lakeland

"The Impact of Emergency Medicine in Medical Care," David Westmark, M.D., Bayfront Medical Center, St. Petersburg

"The Physician's Assistant," Richard A. Henry, M.D., Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville

"The Role of the Division of Health in Delivery of Health and Medical Services," E. Charlton Prather, M.D., Director, Florida Division of Health, Jacksonville

"The Solo Practitioner," Arthur Geller, M.D., Cardiologist, Morristown Memorial Hospital, Morristown, N.J.

"Automated Multiphasic Health Testing," Mr. Don Iverson, President, ICM, Princeton Junction, N.J.

"Status of Medicare in Florida, Mr. George S. Lewis, Blue Shield of Florida, Jacksonville

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons

Saturday—8:30 a.m. to 10:30 a.m.

George L. Irvin III, M.D., Miami
Program Chairman

"Update on Professional Liability"

Moderator: C. Rollins Hanlon, M.D., Director, American College of Surgeons, Chicago, Ill.

Panelists:

William V. Nick, M.D., J.D., Associate Professor of Surgery, Ohio State University School of Medicine, and Editor, *Legal Medicine Press*, Columbus, Ohio
L. Norton Preddy, Defense Attorney, Miami
J. Gerard Converse, M.D., Winter Haven, member of the Executive Committee, Medical Liability Commission

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday—9:00 a.m. to 12:00 noon

Jack Norman, M.D., Miami
Program Chairman

"Nasal Reconstruction," David Slepyan, M.D., Resident, Division of Plastic Surgery, University of Miami Affiliated Hospitals, Miami

"Experiences with the McKissock Reduction Mammaplasty," Bernard M. Barrett Jr., M.D., Resident, Division of Plastic Surgery, University of Miami Affiliated Hospitals, Miami

"Management of Burns of the Hand," Stephen G. E. Cooley, M.D., Miami

"A Review of Microsurgery," Phillip T. George, M.D., Miami

Problem Cases

"The Treatment of Pattern Baldness," Charles P. Vallis, M.D., Lynn, Mass.

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)

Saturday—10:30 a.m. to 12:00 noon

Jacob Green, M.D., Jacksonville
Program Chairman

"The Efficacy of EMI Scanning in Clinical Practice," Roger C. Schnell, M.D., and James B. Perry, M.D., Ft. Lauderdale

"Pancerebral Angiography Via the Retrograde Brachial Route," Charles Freeble, M.D., Jacob Green, M.D., and William Haycook, M.D., Jacksonville

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)

Saturday—8:15 a.m. to 11:15 a.m.

John M. Harper, M.D., Ft. Lauderdale
Program Chairman

"Diagnosis and Treatment of Carcinoma of the Prostate," John T. Grayhack, M.D., Professor and Chairman, Department of Urology, Northwestern University Medical School, and Editor, *Yearbook of Urology*, Chicago, Ill.

"Management of Genito-Urinary Trauma" (Panel)

Moderator: John T. Grayhack, M.D., Chicago, Ill.

Panelists:

William M. Hutchinson, M.D., Jacksonville
Raymond J. Fitzpatrick, M.D., Gainesville
Michael P. Small, M.D., Miami

Milton Coplan Pyelogram Hour

SECTION ON ORTHOPEDIC SURGERY

(Co-sponsored by Florida Orthopedic Society)

Saturday—8:30 a.m. to 12:30 p.m.

Jaime M. Benavides, M.D., Key West
Program Chairman

"Scoliosis in Central Florida," Joseph C. Flynn, M.D., Orlando

"New Concepts of Spinal Orthotics," Newton C. McCullough II, M.D., Associate Professor, Department of Orthopedics and Rehabilitation, University of Miami School of Medicine, Miami

"The Traumatized Foot," Howard P. Hogshead, M.D., Jacksonville

"Use of Bone Scan in Evaluation of Non-union of Fracture," Paul Wallace, M.D., St. Petersburg, Associate Professor, Department of Orthopedics, University of Florida College of Medicine, and Clark Fitzmorris Jr., M.D., St. Petersburg

"Fractures of the Lateral Tibial Tubercle," Lawrence A. Lefkowitz., M.D., Miami Beach

"Athrinosis Ochrinosis," Seymour Morse, M.D., Jacksonville

"Spinal Stenosis and Transazial Tomography," Lester A. Russin, M.D., Miami Beach

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)

Saturday—9:00 a.m. to 12:00 noon

Phillip Frost, M.D., Miami Beach
Program Chairman

"Immunologic Laboratory Methods as Applied to Dermatology," Bruce Rabin, M.D., Ph.D., Assistant Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

"Methoxy Psoralen—Long Wave Ultra-Violet Light Therapy for Psoriasis," John Parrish, M.D., Assistant Professor of Dermatology, Harvard Medical School, Boston, Mass.

(Note: The Section on Dermatology will continue from 1:30 to 2:45 p.m. with a Clinical Pathological Conference and Round Table Discussion)

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

Saturday—9:00 a.m. to 12:00 noon

Henry L. Wright, M.D., Boca Grande
Program Chairman

"Asymptomatic Auto-Amputation of Adnexa," William Drane, M.D., Resident in Obstetrics and Gynecology, University Hospital, Pensacola

"Disseminated Intravascular Coagulopathy Associated with Severe Pre-Eclampsia and Followed by Acute Tubular Necrosis," L. S. Wigginton, M.D., Resident in Obstetrics and Gynecology, University Hospital, Pensacola

"Antenatal Thromboembolism," Larry Capps, M.D., Senior Resident, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa

"Condyloma Accuminata: A New Look at an Old Disease," Larry J. D'Angelo, M.D., Senior Resident, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa.

(Other speakers to be announced)

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday—8:30 a.m. to 11:00 a.m.

Walter R. Gilbert Jr., M.D., Jacksonville
Program Chairman

"The Diabetic Retinopathy Study—Updated Data," Guy O'Grady, M.D., Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami

"Photocoagulation of Macular Disease," J. D. M. Gass, M.D., Professor of Ophthalmology, University of Miami School of Medicine, Miami

"Surgical Correction of Ptosis," Richard R. Tenzel, M.D., Clinical Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami

(Other speakers will include Antonio Gassett, M.D., Assistant Professor, and Frank Pollock, M.D., Associate Professor, Department of Ophthalmology, University of Florida College of Medicine, Gainesville. Titles of their papers will be announced later.)

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)

Saturday—8:30 a.m. to 12:30 p.m.

Hubert A. Aronson, M.D., Miami
Program Chairman

This program will consist of presentation and discussion of several selected interesting neurosurgical cases.

SATURDAY AFTERNOON — APRIL 26

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)

Saturday—1:00 p.m. to 2:45 p.m.

Gerard F. Carter, M.D., Miami
Program Chairman

"The Puzzle of Drug Reactions in 1975," Guinter Kahn, M.D., North Miami Beach, Dermatologist, Parkway Hospital, and Program Director, Pediatric Dermatology Seminar

"Cystic Fibrosis Subclassified," Robert M. McKey Jr., M.D., Coral Gables, Associate Professor and Director of Cystic Fibrosis Center, Department of Pediatrics, University of Miami School of Medicine

"Dysproteinemias from the Clinical Point of View," Jacques R. Caldwell, M.D., Gainesville, Associate Professor of Medicine and Chief, Division of Clinical Immunology, Rheumatology and Allergy, University of Florida College of Medicine

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday—1:00 p.m. to 2:45 p.m.

James L. Talbert, M.D., Gainesville
Program Chairman

Moderator: H. Warner Webb, M.D., Jacksonville

"Surgical Management of Strictures of Trachea and Esophagus," Biemann H. Othersen Jr., M.D., Professor and Chief of Pediatric Surgery, Medical University of South Carolina, Charleston, S.C.

"Diagnosis and Management of Superior Mesenteric Artery Syndrome," Louis Felipe Mencia, M.D., Miami

"Diagnosis and Management of Biliary Atresia in Association with a Congenital Choledochal Cyst," Ronald F. David, M.D., Orlando

"Diagnosis and Management of Cloacal Exstrophy," Jimmy E. Jones, M.D., Pensacola

"Surgical Management of Traumatic Laceration of the Inferior Vena Cava," Ralph L. Swank, M.D., Tampa

"Radioisotope Diagnosis of Splenic Trauma," Burton H. Harris, M.D., Jacksonville

"Surgical Management of Hepatoblastoma," Michel H. Nahmad, M.D., Miami

"Management of Meconium Ileus," Marvin Weinberger, M.D., Miami

"Neuroblastoma—Survival with Bone Metastases," Nasim Ahmed, M.D., St. Petersburg

JOSEPH SPENCER STEWART, M.D.

1895-1974

Late one February afternoon in 1895, Kenesaw mountain was a dark outline of shadow against the glow in the sky. The people of Marietta, Georgia, were still rebuilding their lands and looking to the future, but still glancing back to the heroism and disaster of The War and the March to the sea—just thirty years before. On this day Joe Stewart was born, and without doubt the instinct to build and to help was captured from those near Kenesaw mountain in 1895.

His class of 1918 was graduated early so the new doctors could go to France. Armistice was signed while Joe was at sea. He served in Mesopotamia some two years, and was a prisoner of the Turks. He escaped with several of his hospital staff.

He started practice in the Miami boomtown of 1926. The hurricane swept up Flagler Street and he joined the group to rebuild. The land boom burst! The great depression came, but some of the people here were saying, "Stay! Work, we will have a fine city." Joe was one of these people.

He served as a leader in surgery and as Chief of Staff at Jackson Memorial Hospital. He was president of DCMA, president of FMA, president of Southeastern Surgical Association, active in the American College of Surgeons, and served on the Board of Governors of Southern Medical Association.

World War II took him to Europe where he served with distinction as division surgeon of the Air Transport Command which evacuated 48,000 wounded by air.

But perhaps what he did and tried to do is seen best in all those who loved him. Surgeons in this area still say, "Thanks to Joe for all his help and guidance when I was trying to get started." Another, "I wouldn't be here if he hadn't kept me going the first two years." The little rose on his coat collar spoke of graciousness, kindness and reminds us that perhaps no one man did more than he, through the formative years, to raise the standard of surgery in our community.

It is late afternoon, just thirty years after World War II, I can remember he said to me years ago, "Come on down, medicine is developing, but really the great joy to me is my life with Marian and our children. This love is what makes it all worthwhile." Thanks for such as Joe.

FRANZ STEWART, M.D.

Reprinted from Miami Medicine, January 1975

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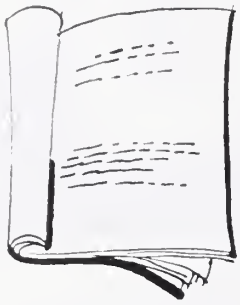

Others Are Saying

The Confidentiality of the Patient Record

"Whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad I will never divulge, holding such things to be holy secrets." (Hippocrates, 460-377 B.C.)

There is at the present time a great deal of genuine concern about the medical record, that fundamental document of patient care. While there are 1,017 million physician-patient visits per year and over twenty-eight million hospitalizations per year in this country, the technical capacity for computer recording and storage of this massive amount of data is presently available. Changes in the old record form to the modified problem-oriented record have also made computerization and storage much more feasible. The fundamental feature of such a computerized record system is easy accessibility.

This system and particularly its accessibility has the public frightened. Both doctors and patients fear that there is no assurance that the vital confidentiality of the record will not be breached revealing not only fundamental medical data but large volumes of personal data. Physicians themselves see the development of PSRO's as another procedure which will provide the medical record to an ever increasing audience of individuals who might, if only inadvertently, breach the confidentiality of the record.

Distressing as it may be, the physician is now confronted with the entirely new and complex problem of dual record keeping. While there are many new record keeping proposals about, one seemingly acceptable one is that proposed by the American Society of Internal Medicine. It is this organization's contention that we should in essence clearly define and essentially rename various levels within a dual record keeping system and propose that the following format be adopted.

The primary or Active Working Record is defined as that traditionally kept and recorded by the patient's attending physician. It may and often does contain information obtained from the patient in total confidence and intended for use by the physician solely for his personal management of the case. The second record of this dual system would be defined as the Permanent Medical Record. This record contains all data referable to the patient's physical and mental health but is prepared for retention by *any* custodian of medical records. This record is devoid of personal comment and of potentially embarrassing or harmful information. Basically it is the usual inpatient or outpatient record with the history, physical examination, progress notes with pertinent laboratory and x-ray data. It usually does contain information provided by individuals other than the physician.

Even brief and superficial consideration of our current medical chart system reveals that all of this information is in one record only. Separate records with different information have not been considered necessary. We have all been taught that the chart should be "complete." It is this completeness—a common pool of medical data and potentially harmful personal data—that patients and physicians alike feel should not be indiscriminately made available to just any prying and interested party. It is now specifically suggested that these two records be kept clearly separate and distinct. It is proposed that the level one or Active Working Record be the property of the physician intended solely for his personal use in connection with the diagnosis and treatment of the patient. It is this record which retains its priviledged status unless such privilege is used to affect the patient's rights, benefits or liabilities in which case its use is subject to due process requirements.

The second level record, the Permanent Medical Record belongs to the physician and his patient. This permanent data base and the release thereof should not occur except with the dual consent of both parties and then only for the purpose of treatment and patient management. Exceptions to this dual consent requirement would be possible only in the instance of legal action again requiring adherence to due process guarantee. This second level record would be that made available for PSRO patient claim validation, the patient's profile, and the physician profile. This second level record or permanent medical record must be subject to all of the confidentiality and security procedures usual for the protection of such information. Surrender of this record at anytime must be clearly effected only after a careful assessment of the "need to know" of the requesting party or organization.

Most physicians find the subject of record and record keeping less than attractive to contemplate. However, while we proceed upon our daily business of caring for patients, radical changes in the record system have already been brought about and will continue to be brought about with frighteningly little input from the physician and the patient, the two most vitally concerned parties. Distasteful as it may be medical societies, specialty societies, and individual physicians must participate in the decision making process which is presently coming about. It is quite reasonable to state that there is at present a crisis in the confidentiality and the privileged state of information which has been traditionally existent between physicians and patients.

ROY H. BEHNKE, M.D.

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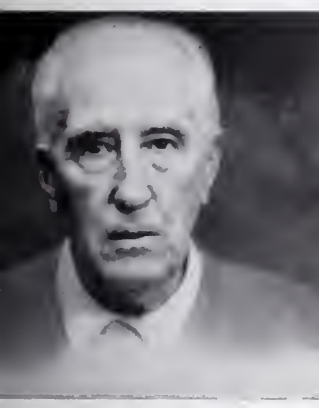

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Medical News

INFORMED CONSENT LEGISLATION SUGGESTED . . . At the American Bar Association meeting in Honolulu last August, talking on the subject of the doctrine of informed consent, Burr B. Markham, an attorney from Minneapolis, suggested that the ABA recommend legislation which would standardize the evidentiary proof to establish a *prima facie* case of informed consent.

Such legislation, he said, should require: (1) medical testimony to establish that only the material risks of a medical procedure as are generally recognized by the medical profession need to be disclosed; and (2) that no patient shall be required to be informed of the medical risks of a medical procedure if such patient shall advise a physician he does not want to be so informed and appropriately confirms such in writing.

William V. Gough, an attorney from Rochester, N.Y., noted that misuse of the informed consent doctrine has been corrected in many recent court decisions.

ALFRED L. LEWIS SCHOLARSHIP . . . The Capital Medical Society has presented its first Alfred L. Lewis Memorial Scholarship to Mr. Tim Byrd of Panama City, a student in the Medical Sciences Program at Florida State University in Tallahassee. Dr. Lewis was a well-known Florida pathologist, active in the affairs of the Florida Medical Association. He was killed in an auto accident on a Tallahassee street about two years ago.

DEATH CLAIMS HARRY T. GRAY, FMA ATTORNEY . . . Harry T. Gray, of Jacksonville, longtime attorney for the Florida Medical Association, died in a Jacksonville hospital on January 11. The senior partner in the law firm of Marks, Gray, Conroy and Gibbs, Mr. Gray was a former president of the Jacksonville Bar Association. He also was a member of the American Bar Association and Florida Bar Association and served as President of the Association of Insurance Attorneys in 1960. Survivors include the widow, Mrs. Muriel B. Gray; a daughter, Mrs. Helen Grace Solomon of New York; and two grandchildren.

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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults – 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children – 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many stroins are known to be resistont, routine sensitivity testing is recommended.

Opinion & Dialogue

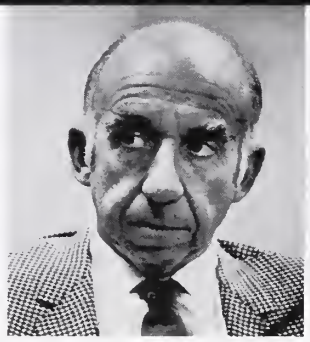
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

s He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

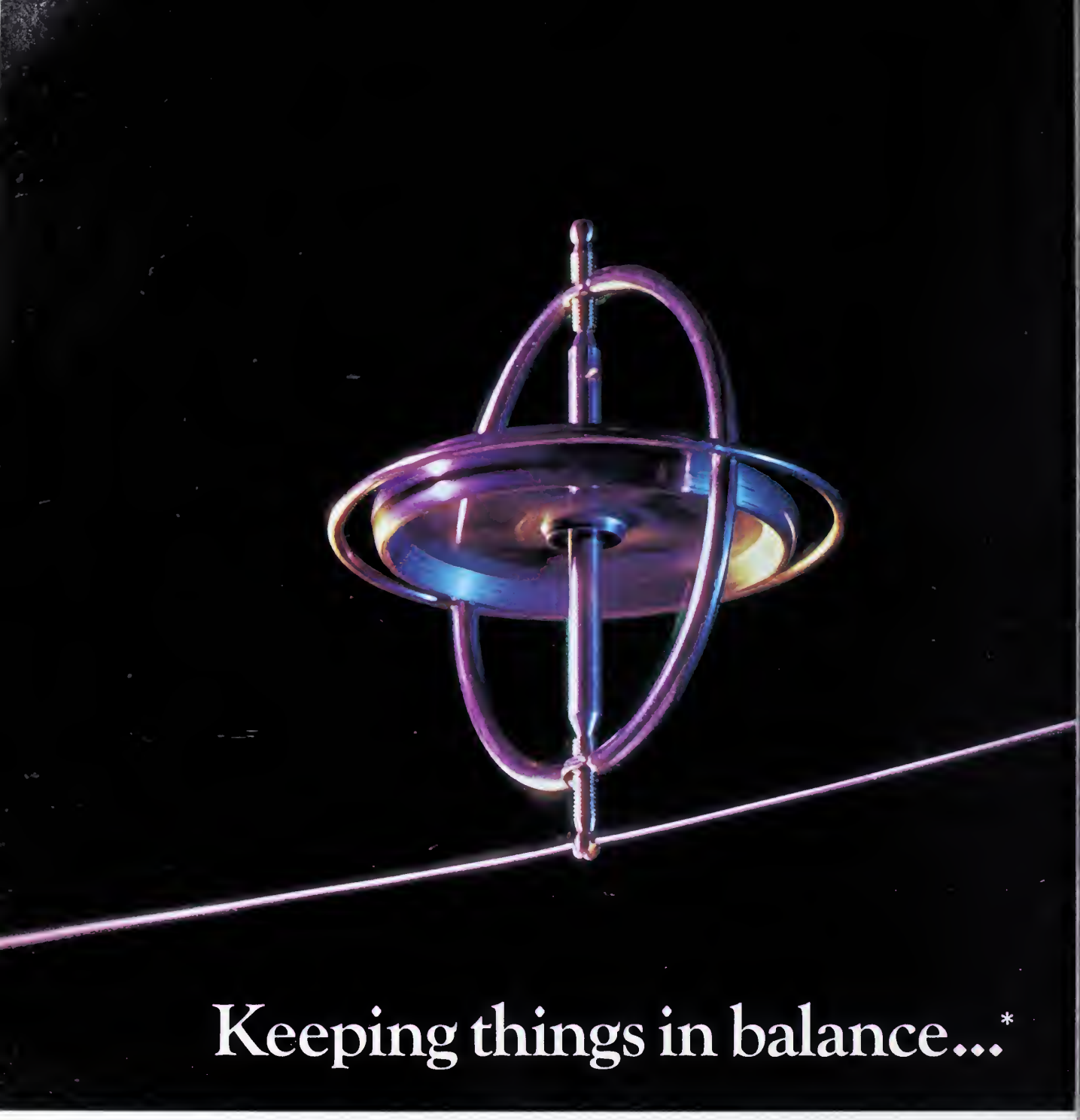
The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



Keeping things in balance...*

Antivert®/25 Tablets
(25 mg. meclizine HCl)

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 1 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cl palate. Congeners of meclizine have caused cleft palate in species other than the r

Meclizine HCl is contraindicated in individuals who have shown a previo hypersensitivity to it

WARNINGS. Since drowsiness may, on occasion, occur with use of this dru patients should be warned of this possibility and cautioned against driving a car operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in childr have not been done; therefore, usage is not recommended in the pediatric age grou

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer

A division of Pfizer Pharmaceutica
New York, New York 10017

The rectal thermometer & NEOPAP® SUPPRETTES™

(acetaminophen suppositories)

a rational regimen for childhood fever.

NEW 5gr STRENGTH

Antipyretic for children

- No salicylate side effects
- Store without refrigeration
- Convenient rectal administration
- Available only by prescription
- Grooved for one-half suppository administration

Description: NEOPAP SUPPRETTES are available for rectal administration in potencies of 2 gr or 5 gr of acetaminophen in NEOCERA® Base (a unique blend of water-soluble Carbowaxes*).

Indications: For management of fever associated with common childhood infections.

Contraindications: Sensitivity to acetaminophen or the suppository base.

Warnings: Not for use in children under three years of age. Should not be administered repeatedly to patients with pulmonary, cardiac, renal, or hepatic disease.

Precautions: Prolonged administration may result in such withdrawal symptoms as restlessness and excitement when the drug is discontinued.

Adverse Reactions: No significant adverse reactions have been reported with NEOPAP (acetaminophen) SUPPRETTES. However, adverse reactions associated with administration (usually chronic) of this drug have included the following:

Blood: Cyanosis, methemoglobinemia, sulfhemoglobinemia, and hemolytic anemia; neutropenia, leukopenia, and pancytopenia.

Allergic: Skin eruptions, urticaria, fever.

Other: Hypoglycemia, CNS stimulation, jaundice.

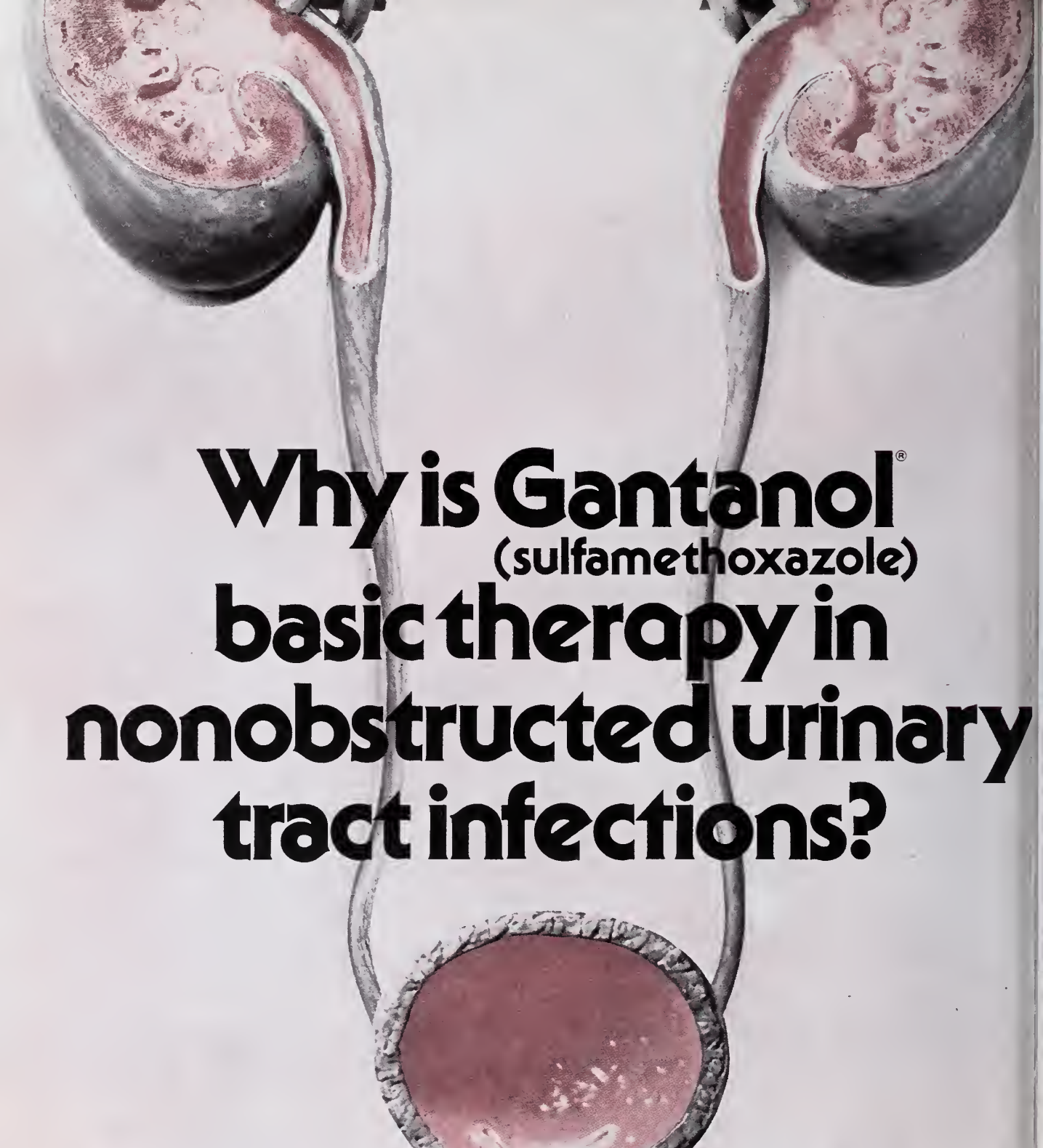
Dosage and Administration: Children 3 to 6 years of age: One 2 gr suppository rectally 3 or 4 times daily; not to exceed 8 grains per day.

Children 6 to 12 years of age: One 5 gr suppository rectally 3 or 4 times daily; not to exceed 20 grains per day.

*Trademark Union Carbide.

WEBCON

Webcon Pharmaceutical Division
ALCON LABORATORIES, INC.
P.O. Box 1629
Fort Worth, Texas 76101



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
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- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

ura, hypoprothrombinemia and methemoglobinemia); *allergic eactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral njection, photosensitization, arthralgia and allergic myocarditis); *astrointestinal reactions* (nausea, emesis, abdominal pains, hepatis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* headache, peripheral neuritis, mental depression, convulsions, taxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous eactions* (drug fever, chills, toxic nephrosis with oliguria and nuria, periarteritis nodosa and L.E. phenomenon). Due to certain hemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have aused rare instances of goiter production, diuresis and hypoglyemia as well as thyroid malignancies in rats following long-term dministration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
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HILL CREST HOSPITAL — For Intensive Treatment of Psychiatric Disorders

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

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Administrator:

Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: (205) 836-7201

Classified Ads

physicians wanted

Family Practitioners

WANTED—Family practitioner to join established physician in busy two-doctor practice. Salary and/or percentage first year with PA benefits. Lower Florida East Coast. Phone (305) 732-2701.

FAMILY PRACTITIONER for growing community. Established family physician needs associate for office with lab in northeast Florida. On St. Johns River—excellent fishing, hunting, sports. Accredited Junior college and schools. New 120-bed hospital opening late 1975. Internists, pediatricians, OB-Gyn needed in community. For information: Kathleen Santi, M.D., 1401 South Palm Ave., Palatka, Florida 32077. (904) 328-3157.

FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone Collect: (904) 973-6561.

GENERAL PRACTICE: Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

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GENERAL PRACTITIONER (over 40) for group practice in fully equipped clinic in central Florida, serving four surrounding counties. Two hospitals in community. Mail curriculum vitae to George E. Engelhard, M.D., 1027 West Main, Leesburg, Florida 32748.

GENERAL PRACTITIONER: For general or private practice, central Florida. Staff privileges available at 162-bed Lake Community Hospital. Contact Administration, Lake Community Hospital, 700 North Palmetto, Leesburg, Florida 32748.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA. Seven man multi-specialty, fee-for-service group is seeking an internist to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

PSYCHIATRIST for hospital and office practice in Florida's most prosperous city. Seven psychiatrists will welcome you. New 75-bed hospital underway. Office space available. Contact Robert G. Head, M.D., 1630-A North Plaza Dr., Tallahassee, Florida 32303.

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ANESTHESIOLOGISTS associate wanted—board certified or eligible, to join multiman professional association in sunny Miami, with many fringe benefits. Progress to full partnership in two years. Curriculum vitae and letter of recommendation from program director helpful. Please contact: Administrator, P.O. Box 640089, Miami, Florida 33164.

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NEUROLOGIST: For general or private practice, central Florida. Staff privileges available at 162-bed Lake Community Hospital. Contact Administration, Lake Community Hospital, 700 North Palmetto, Leesburg, Florida 32748.

GASTROENTEROLOGIST: For general or private practice, central Florida. Staff privileges available at 162-bed Lake Community Hospital. Contact Administration, Lake Community Hospital, 700 North Palmetto, Leesburg, Florida 32748.

HEMATOLOGIST: For general or private practice, central Florida. Staff privileges available at 162-bed Lake Community Hospital. Contact Administration, Lake Community Hospital, 700 North Palmetto, Leesburg, Florida 32748. Phone (904) 787-6881.

INTERNAL MEDICINE CARDIOLOGIST: Excellent opportunity to join three young internists in an active young south Miami practice. Excellent salary and benefits. Full partnership in two years. Contact Monroe Scheiner, M.D., 9000 Coral Reef Drive, Miami, Florida 33157. Phone: (305) 251-3434.

COMMUNITY-TRAINED PSYCHIATRIST WANTED: Medical Director for Community Mental Health Center in north Florida. Responsible for clinical aspects of a comprehensive center; program development, staff training and supervision. Must assume portion of evening and weekend emergency coverage. Primary and backup services shared by consulting psychiatrists. Require community orientation and experience, Florida licensure and board eligible or certified. Attractive mid-sized university community, one and one half hours to beaches. Salary competitive and negotiable. Please reply with resume and earliest availability for interview and employment. Sarah Morrill, ACSW, Director, Apalachee Community Mental Health Services, 1016 Thomasville Road, (904) 224-9633, Tallahassee, Florida 32303.

ENT-OBG-PED—You owe it to yourself to check this out. You practice medicine, clinic administration does the rest leaving you time to enjoy growing southwest Florida waterfront community. Contact: G. F. Tallmadge, Administrator, Charlotte Inter-Medic Health Center, 297 S. Tamiami Dr. N.W., Port Charlotte, Florida 33952. Phone: (813) 629-7501.

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Miscellaneous

Family Practitioner, Otolaryngologist, Pediatrician, Internist-Rheumatologist, and Internist-Pulmonary Disease needed for outstanding practice opportunities. Forty-six physician medical group, affiliated with 312 bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

ATTENTION—DOCTORS OF MEDICINE: Are you tired of fighting the problems of the megatropolis? If so, we may have an attractive offer for you. Consider establishing a practice in the rural area of north Florida. Enjoy easy living with all the advantages of big city life. For further information call Bob Howard, Administrator, Suwannee County Hospital at 362-1413.

EMERGENCY ROOM PHYSICIAN to increase staff of new facility located in attractive environment in north Florida. Outstanding remuneration offered. If interested send your curriculum vitae. Write C-662, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST OR GENERALIST WANTED to join two doctor practice in internal medicine and geriatrics. Beach area Fort Lauderdale. Florida license. Salary first six months, then partnership. Excellent hospital privileges. A. Joseph Pitone, M.D. and Louis L. Amato, M.D., 2600 N.E. 9th St., Fort Lauderdale, Florida 33304. Phone: (305) 564-7597.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact: Jake Truslaw & Company, P.O. Box E-S, Venice, Florida 33595. Phone: (813) 485-4617).

FLORIDA GOLD COAST. ALL SPECIALISTS NEEDED IN TOWN. The *only* professional condominium in the area. Buy now and design your office while building is being constructed. Ready for occupancy about May 1975. Contact Milton Lavernia, Reg. Real Estate Broker, Deerfield Beach, Florida 33441. Phone: (305) 399-1550 or 395-6078 evenings.

PHYSICIANS WANTED: Pediatrician, family practitioner, internist-cardiologist, urologist, psychiatrist, orthopedic surgeon, general surgeon qualified in thoracic and cardiovascular surgery. Liberal financial assistance. No investment required. Contact Claude Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

GATEWAY HOSPITAL—Florida's newest hospital in St. Petersburg, 301-bed now under construction, completion November 1975. 48,000 sq. ft. office space available September 1975 adjacent to hospital. ALL TYPES PHYSICIANS NEEDED. For further information contact Bernard L. Samson, Gateway Hospital Corp., 2600—9th St., N., St. Petersburg, Florida 33704. Phone (813) 822-8716.

FLORIDA, ST. PETERSBURG: Emergency Physicians needed to join dynamic, ambitious, expanding group on Florida west coast. Outstanding opportunity economically and professionally beautiful location. Florida license required. US graduates only. Send curriculum vitae or resume with inquiry to: Emergency Physicians, 5335—66th Street North, Suite # 14, St. Petersburg, Florida 33709.

OLAF WIEGHORST Limited Edition Western Art prints in full color. Signed and numbered. For color brochure write: OWFA, 3508 Highland, Manhattan Beach, CA 90266: (213) 545-3577.

situations wanted

BOARD CERTIFIED SURGEON, subspecialty vascular surgery, seeking solo, group, associate practice, prefer large community, available July 1975, Florida licensed Write Ishwar Bhuta, M.D., 4199 Kostka Drive, Memphis, Tennessee 38116.

PEDIATRICIAN, 38, married, board certified, Florida license, excellent U.S. training, bilingual (English-Spanish), wishes to combine general pediatrics with neonatology, in group, multispecialty or hospital-based practice. Write C-655, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Florida licensed M.D., 20 years EENT experience desires job doing medical EENT, medical ophthalmology, and/or refractions. Lewis W. Moore, M.D., 1404 Dodds Avenue, Chattanooga, Tenn. 37404 or phone (615) 622-0002.

real estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

OFFICE SPACE, 1,300 sq. ft., partitioned and air conditioned, adjoining Tampa's best neighborhood. Excellent for G. P., internist or pediatrician. Rent $550 per month Inquire Fermin Rodriquez, phone: (813) 839-8431.

NOW LEASING: 60,000 sq. ft. medical building now under construction in north Tampa, next door to University Community hospital, a private 400-bed general hospital, same area as medical school and VA hospital. Ready for occupancy early in 1975. Call Tampa 971-5353 or 977-0144.

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FORT MYERS, FLORIDA—MEDICAL SUITES in the all new "Landmark," a condominium professional office building, adjacent to the new Community Hospital. You may purchase, lease or lease with option to purchase. Call or write today. King Symonds Realty, Inc., Realtor, 3916 Cleveland Avenue, Fort Myers, Florida 33901. Phone: (813) 936-4186.

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ST. PETERSBURG. Pasadena Medical-Dental Building East, 500 Pasadena Avenue South. New DeLuxe Office Building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Jim Allen, Inc. (813) 347-1243.

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equipment for sale

FOR SALE: Medical equipment, instruments, examining room suite. Hamilton nu-tone blond mahogany furniture (examining table, treatment cabinet, instrument cabinet, waste receptical); stool, Pelton & Crane autoclave, hyfrecator; diathermy; spot-quartz lamp, Castle examining spotlight, stainless instruments, supplies, etc. Contact Mrs. Ellsworth Waite, 1530 Riverside Dr., Holly Hill, Florida 32017. Phone (904) 252-7424.

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The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of clinical efficacy

- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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Division of Hoffmann-La Roche Inc.
Nutley New Jersey 07110

Bactrim™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of antibacterial activity
in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which appears on preceding page.

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OF THE FLORIDA MEDICAL ASSOCIATION, INC. • MARCH 1975

ATTEND THE FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING
APRIL 23-27, 1975 — MIAMI BEACH

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major ymptoms, she is a psychoneu-otic patient with severe nxiety. But according to the escription she gives of her elings, part of the problem ıay sound like depression. 'his is because her problem, lthough primarily one of ex-essive anxiety, is often accom-anied by depressive symptom-tology. Valium (diazepam) an provide relief for both—as ıe excessive anxiety is re-eved, the depressive symp-oms associated with it are also ften relieved.

There are other advan-ıges in using Valium for the ıanagement of psychoneu-otic anxiety with secondary epressive symptoms: the sychotherapeutic effect of 'alium is pronounced and apid. This means that im-rovement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

MAR 21 1975

urveillance because of their predisposi-on to habituation and dependence. In regnancy, lactation or women of child-earing age, weigh potential benefit gainst possible hazard.

recautions: If combined with other psy-hotropics or anticonvulsants, consider arefully pharmacology of agents em-loyed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate s action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

Attitude of Doubt

Some nonphysicians with health and legislative interests have a skeptical attitude toward physicians. They question our sincerity when we talk about what is best for the patient, our motives when we espouse a cause and our expertise when we presume to advise them about health related matters. Where once there was certainty that our primary concern was for the welfare of the sick, there is now uncertainty. Our actions are being analyzed; the results do not always reflect our best selves.

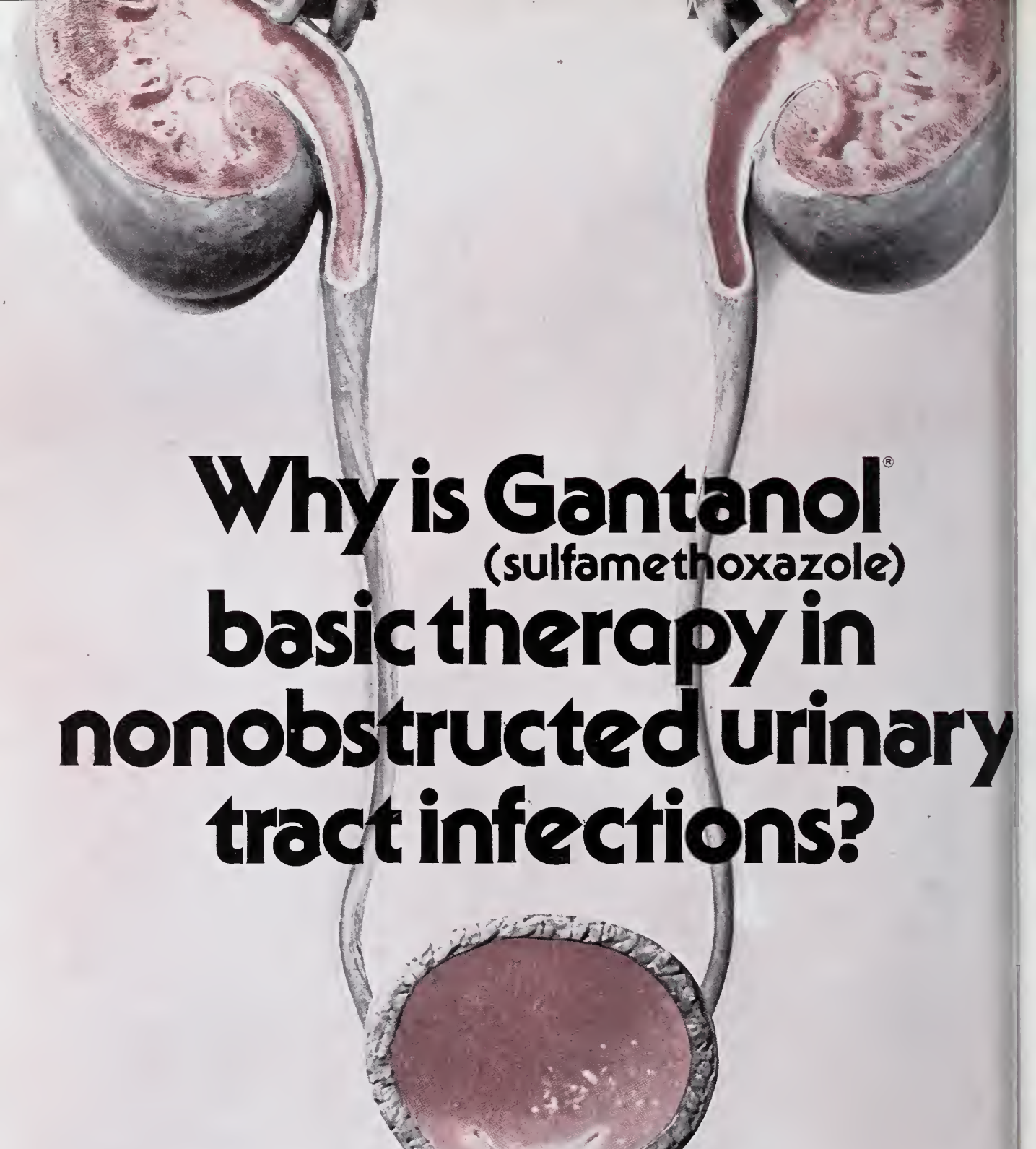
Unfortunately, physicians are beginning to look at each other with these same attitudes. As do our detractors, we question the motives and reasoning of those with whose opinions we differ. We must realize that down this road lies a gradual erosion of our strength and effectiveness.

Our training has failed to prepare us for the nonmedical roles we have been forced into. In a group, perhaps, our shortcomings become more obvious and our temperaments more abrasive. But we must put aside our unreasonable doubts, search for what is sincere and work toward what is best for medicine and for the patient. To maintain a high level of medical competence is something we understand and agree upon. This is our reason for being.

No one among us has the solution to our problems, but each member should be heard without doubts or questions about his motives. We should stop to listen, be willing to reason, accept and recognize the new and different. We must work together with understanding in search for what is best for all.

Let us not regard our peers as we are regarded by our critics.

Thad Moseley



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

...ura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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Deaths

Bullwinkel, Bob, Ormond Beach; born 1931; Harvard Medical School, 1956; member AMA; died September 22, 1974.

Cohen, Maurice, Tampa; born 1920; Tulane University, 1952; member AMA; died August 25, 1974.

Croll, Diane, Tampa; born 1914; University of Manitoba, 1940; member AMA; died July 29, 1974.

Cross Ralph E., Homestead; born 1918; University of Tennessee, 1942; member AMA; died September 18, 1974.

Dyett, John Henry, West Palm Beach; born 1895; Howard University, 1925; member AMA; died October 17, 1974.

Ferrara, Hugo Alfonso, Miami; born 1919; Havana University, 1944; member AMA; died August 4, 1974.

Field, Richard David, Winter Haven; born 1917; Tulane University, 1942; member AMA; died January 2, 1975.

Gilbert, N. Stuart, Miami; born 1902; L. I. College, 1926; member AMA; died November 7, 1974.

Gryte, Lewis Adolph, Largo; born 1894; University of Manitoba, 1921; member AMA; died December 29, 1974.

Kantor, Norman, Coral Gables; born 1927; University of Oklahoma, 1955; member AMA; died November 13, 1974.

Kelly, David M., Tampa; born 1937; State University of Iowa, 1963; member AMA; died August 18, 1974.

Levin, Nathaniel M., Miami; born 1901; Temple University, 1930; member AMA; died November 20, 1974.

McMackin, John Vinson, North Miami; born 1899; Tufts Medical School, 1923; member AMA; died November 15, 1974.

Mellen, Noel C., Pensacola; born 1908; University of Pennsylvania, 1935; member AMA; died September 21, 1974.

Metzger, Frank Curry, Tampa; born 1892; University of Cincinnati, 1915; member AMA; died October 16, 1974.

Murphey, Daniel Forney Hoke, St. Petersburg; born 1909; Vanderbilt University, 1935; member AMA; died December 6, 1974.

Pearson, Homer Colquitt, Miami; born 1901; Emory University, 1925; member AMA; died December 26, 1974.

Rash, Jack Otway Watkins, Tequesta; born 1909; University of Louisville, 1934; member AMA; died December 23, 1974.

Singha, Cedric Raj, Avon Park; born 1934; King Edwards Medical College, 1959; member AMA; died December 16, 1974.

Stanley, Gordon Douglas, Sanford; born 1919; Duke University, 1951; member AMA; died October 25, 1974.

Stewart, Joseph Spencer, Coral Gables; Past President FMA; born 1895; University of Georgia, 1918; member AMA; died November 29, 1974.

Walter, Eugene P., Jacksonville, born 1923; Tulane U., 1958; member AMA; died October 22, 1974.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension
Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

Ortho announces
a unique,
broad-spectrum
anthelmintic
effective against
whipworm...
new
Vermox
TRADEMARK
chewable
tablets
(mebendazole)
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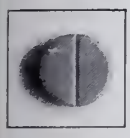
...and highly effective against roundworm, hookworm and pinworm in single or mixed infections



No dosage calculations — one simplified dosage, regardless of weight or age†

whipworm, roundworm, hookworm and mixed infections:
1 chewable tablet b.i.d. for 3 consecutive days

pinworm: 1 chewable tablet

If the patient is not cured three weeks after treatment, a second course of treatment is advised.

highly effective

	Mean cure rates	Mean egg reduction
Whipworm	68%	93%
Roundworm	98%	99.7%
Hookworm	96%	99.9%
Pinworm	95%	— — —

simplicity of administration patients can take the tablet at any time. It can be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

not a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

convenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

well tolerated transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

†Vermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Indications Vermox* (mebendazole) is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.

Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Haokworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

Contraindications Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults.

For control of trichuriasis, ascariasis, and hoakworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

Ortho Pharmaceutical Corporation,
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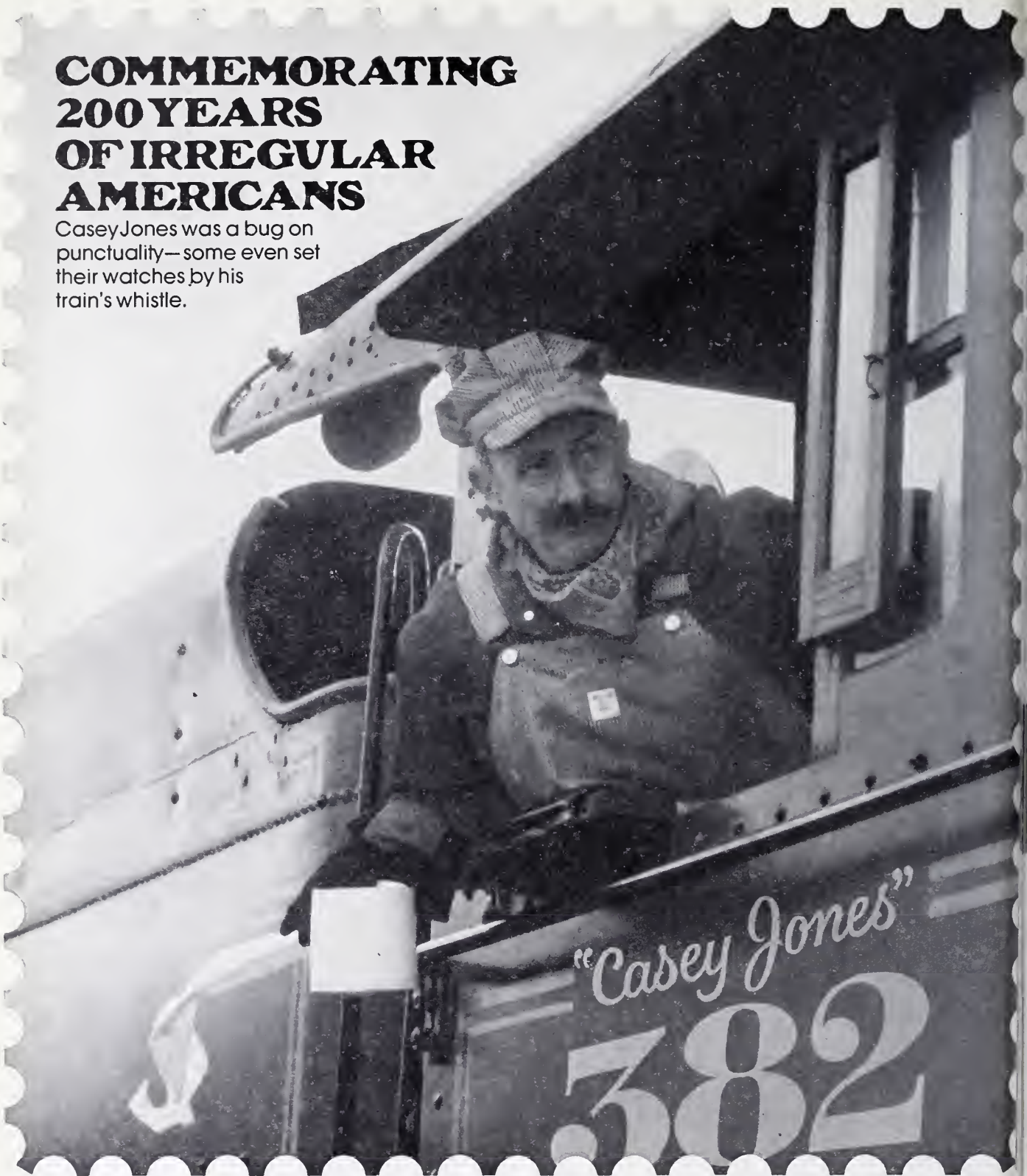
COMMEMORATING 200 YEARS OF IRREGULAR AMERICANS

Casey Jones was a bug on punctuality—some even set their watches by his train's whistle.



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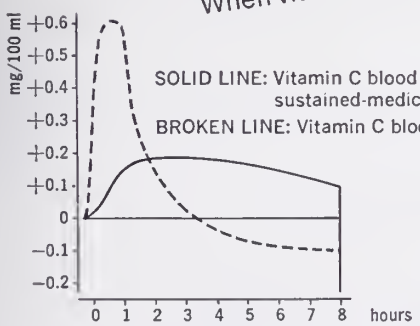
"This method [CEVI-BID] provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."[1]

When vitamin C is indicated . . . prescribe CEVI-BID.



SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).

BROKEN LINE: Vitamin C blood levels obtained with tablets.

*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Others Are Saying

In-Hospital Review Systems

The Dade-Monroe Professional Standards Review Organization will establish, implement and operate an inpatient hospital review system in all PSRO certified hospitals in 1975.

Detailed review and operational manuals will be developed. The various specialty societies will also develop criteria with AMA sanction. The nationally developed criteria will be used as guidelines only, for local adoption or modification. Briefly, noncertified days should not be reimbursed. Hospitals will continue to maintain their existing methods for determining patient eligibility. A physician is the only one who can make denials or extension benefits. A PSRO nurse, record administrator, etc. can make approvals based on criteria guidelines.

The Dade-Monroe PSRO will establish liaison with all necessary departments. Once review data is obtained by diagnosis and physician, review may not be needed in the future for that diagnosis/physician. Review will be performed within 24 to 48 hours after admission. Certification will be placed on the chart. The Utilization Review Committee, or equivalent, will serve as the appeal body.

The PSRO Program Coordinator will coordinate the length of stay by diagnosis, age, complications, etc. as noted on the progress record. PSRO will also assist in discharge planning, nursing homes, home health agencies, etc., using the hospital facilities as needed. The Dade-Monroe PSRO will conduct Medical Care Evaluation Studies, the emphasis being on the delegation of this responsibility to individual hospitals as they qualify. This qualification will be based on outlines of the JCAH or the American Hospital Association's QAP Program. The designated hospital must provide the criteria it will use.

Nondelegated hospitals will use a Dade-Monroe PSRO Committee to conduct the Medical Care Evaluation Studies. Under no circumstances will a member of a staff review his own patients in that hospital.

A recent physician survey in *Medical World News*, Oct. 25, 1974, revealed the following PSRO attitudes. Physicians less than 45 years of age favor PSRO (54.9%). Hospital-based physicians favor (61.8%). Pediatricians and Psychiatrists are in high favor. Internists, Family Practitioners, and especially Surgeons, don't want it. Over 80% of the physicians interviewed see government expansion beyond Medicare and Medicaid.

Your Editor writes this abbreviated editorial mainly for informational reasons. Over 1,300 physicians in Dade-Monroe have written of their willingness to join your own PSRO Corporation. The decision is yours. Know the facts and the work involved in implementation.

Edward W. St. Mary, M.D., Editor
Miami Medicine

Reprinted from Miami Medicine, December 1974

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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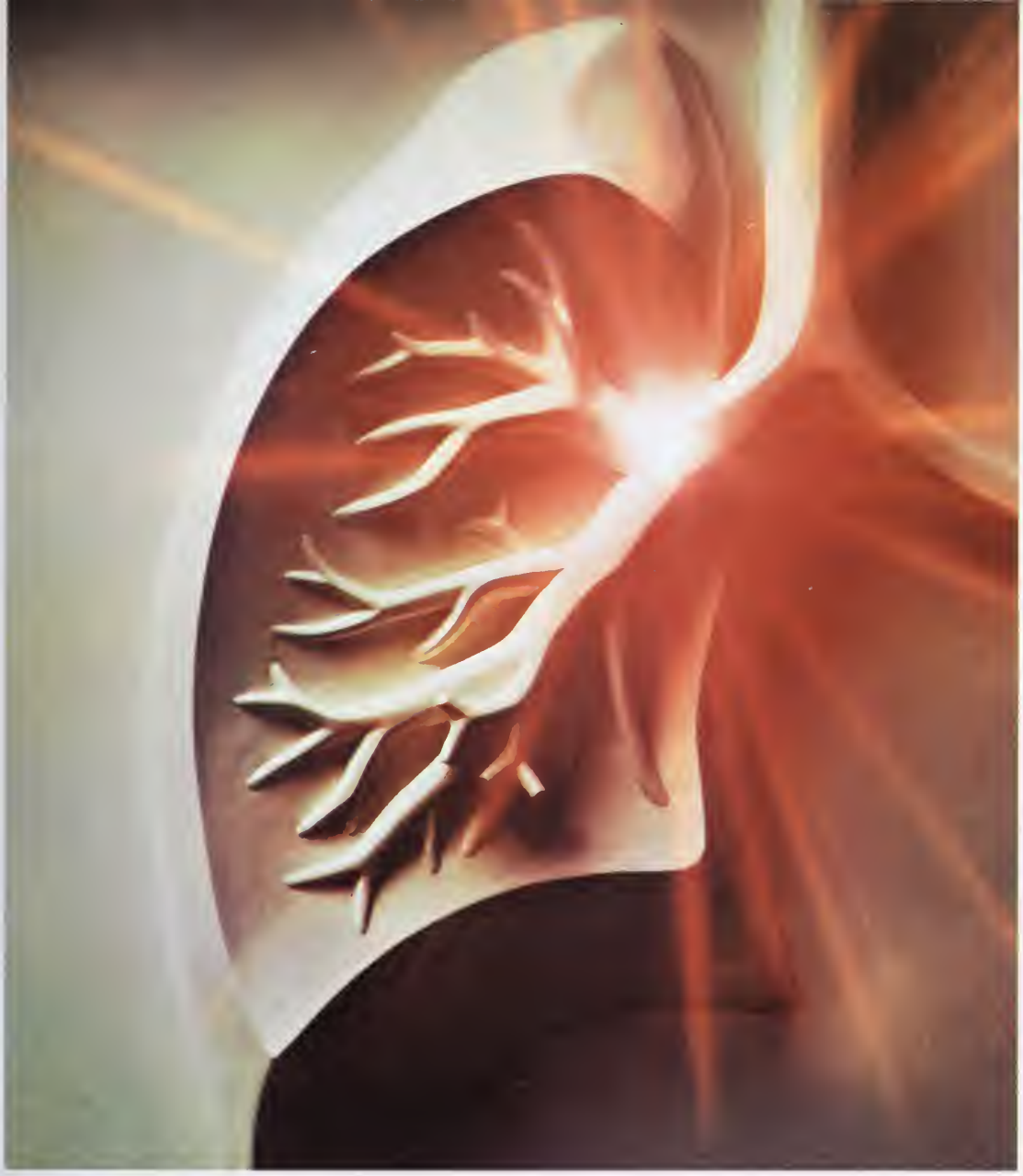

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended

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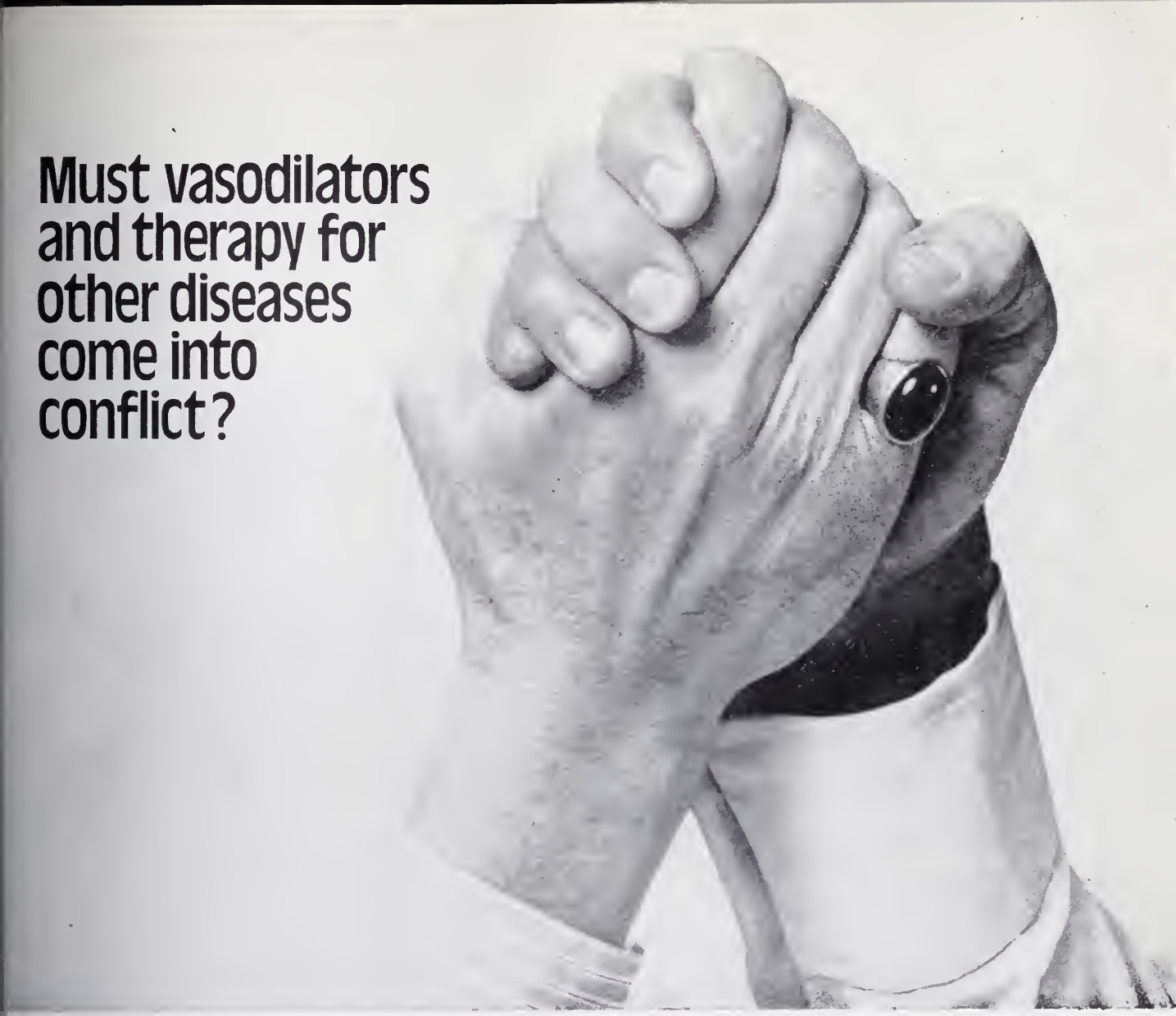
Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective.

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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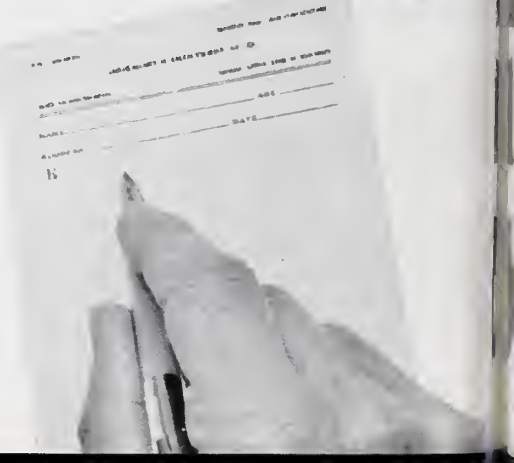
Bioequivalence



:he weight of scientific opinion:

If the pharmacist substituted a ıemically equivalent drug for the ıe you have specified for your atient—could you be certain of that roduct's safety and effectiveness mply because the chemical content as the same?

Definitely not, unless bio-quivalence tests and other quality surance checks had been conducted. he pharmaceutical industry and any scientists have maintained this osition for years, but others have uestioned it. Now the Office of echnology Assessment of the ongress of the United States has ported on the issue in its Drug ioequivalence Study.*

Here are a few definitive state-ents in the O.T.A. report:

"...the problem of bioinequiva-ncy in chemically equivalent prod-cts is a real one. Since the studies in hich lack of bioequivalence was emonstrated involved marketed roducts that met current compen-al standards, these documented in-ances constitute unequivocal vidence that neither the present andards for testing the finished roduct nor the specifications for aterials, manufacturing process, nd controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MARCH, 1975 • VOLUME 62 • NUMBER 3

Computerized ECG and Community Practice

A Note of Caution

C. P. RILEY, M.D. AND W. H. LANGHORNE, M.D.

Abstract: A case of myocardial infarction is presented that illustrates both an error in clinical judgment and in computer interpretation of the electrocardiogram. Review of serial tracings and confidence in the initial clinical impression would have established the correct diagnosis. The busy practitioner without training or confidence in ECG interpretation may become too dependent on the computer for a medical diagnosis. The deficiencies of computer programs in the diagnosis of complex arrhythmias as well as the lack of routine comparison of ECGs should be emphasized to the physician who has been influenced to use this system. Continued physician education and his awareness of the present state of computer reliability may alleviate this problem.

Mechanization of ECG interpretation may eventually improve patient care by reducing costs and saving physicians' time. Crevasse and Ariet[1] have described one system being offered to physicians in a predominantly rural area of the southeastern United States. The Bonner program[2] described in this report may be the best currently available, but problems remain which should restrict complete acceptance of any computer service at this time.[3]

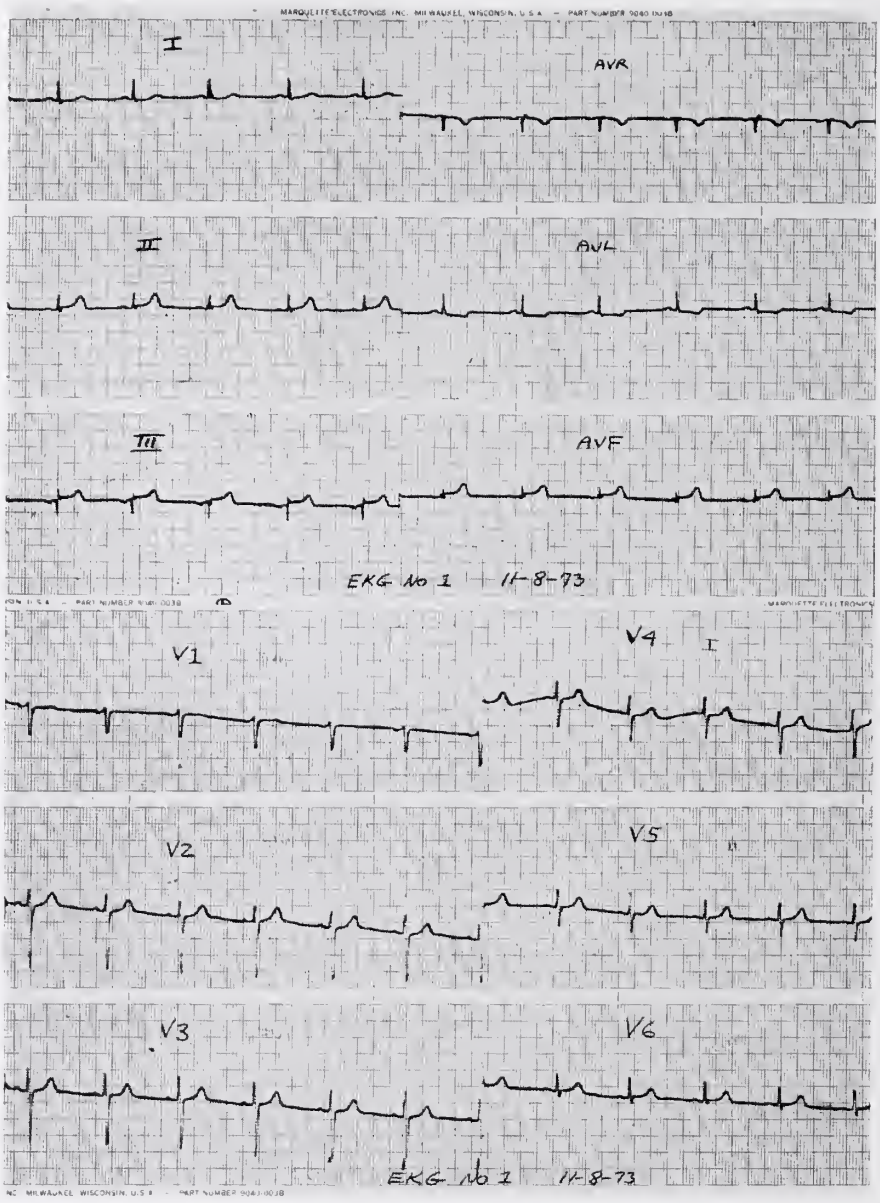
The following case report demonstrates an example of an error in patient management caused by reliance of the physician on an inadequate computer ECG interpretation. Lack of review of serial tracings by the computer and the physician was responsible for the error.

Case Report

This 48-year-old man experienced crushing substernal chest pain and diaphoresis while engaged in heavy physical labor. The patient's physician suspected acute myocardial infarction and the patient was promptly hospitalized. Serum enzymes showed a rise and fall characteristic of acute myocardial infarction, but serial electrocardiograms were initially read as normal by the computer. The first electrocardiogram showed 0.1 mv ST elevation in leads II-III and aVf with minor reciprocal depression in leads I and aVl; these were not mentioned in the initial computer interpretation (Fig. 1). The following day an electrocardiogram showed a leftward axis shift (+10° to -4°) and the development of Q waves in leads III and aVf (Fig. 2). The clinical history made the diagnosis of myocardial infarction likely, and the ECG changes, although "nondiagnostic," confirmed the clinical impression. This possibility was not mentioned by the computer, however, a statement was given that the ECG should be reviewed by a physician. A diagnosis of myocardial infarction was not established, and the patient was allowed to ambulate without monitoring. A workup for possible gastrointestinal disease was started. An electrocardiogram three days later showed diagnostic Q waves in leads II, III and aVf and was then correctly identified by the physician and the computer as compatible with an inferior myocardial infarction (Fig. 3). It is of interest that the computer interpretation obtained the following day contained a warning that the "infarction statement may be incorrect because of measurement error!" The physician, understandably confused, then transferred his patient to a cardiologist in a larger community. The patient's recovery was subsequently uneventful.

Comments

This report displays two errors in patient care, which, fortunately, resulted in no lasting harm for the patient. The first is partly due to the physician's lack of confidence in his clinical judgment, which was initially correct. Continuing education programs may sharpen his diagnostic skills. Unfortunately, many busy practitioners feel that a computer ECG interpretation represents an easier way to improve their management of patients with chest pain. Claims of

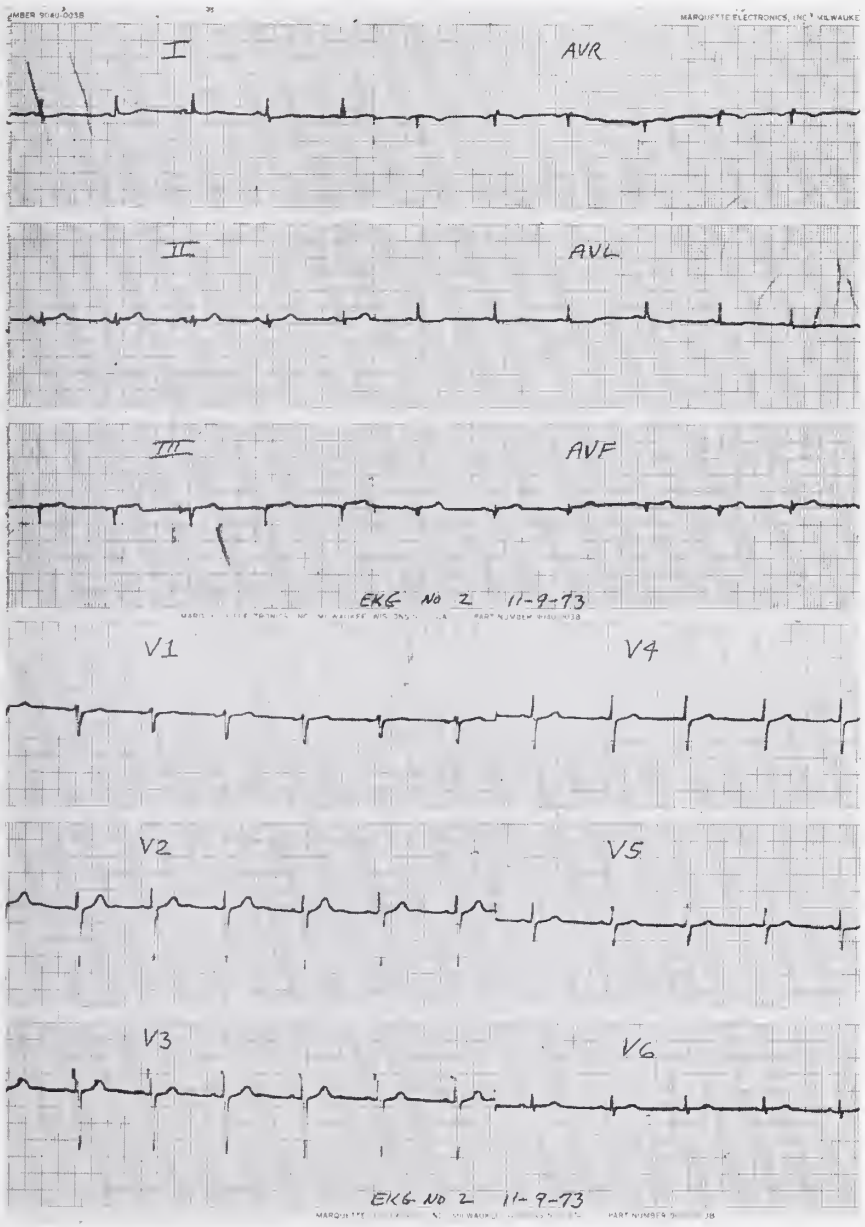


EKG Processing Center—University of Florida
This Interpretation Must Be Reviewed By A Physician
Patient No. 25126323
Date 11-8-73 Time 21 hrs. 4 min.

Normal Sinus Rhythm, Rate 64
Normal ECG

INTERVALS IN MILLISECONDS					FRONTAL PLANE ANGLES IN DEGREES				
P-R	QRS	Q-T	T	P	QRS	P	T	J	QRST
128	94	363	170	104	10	-04	77	None	46x

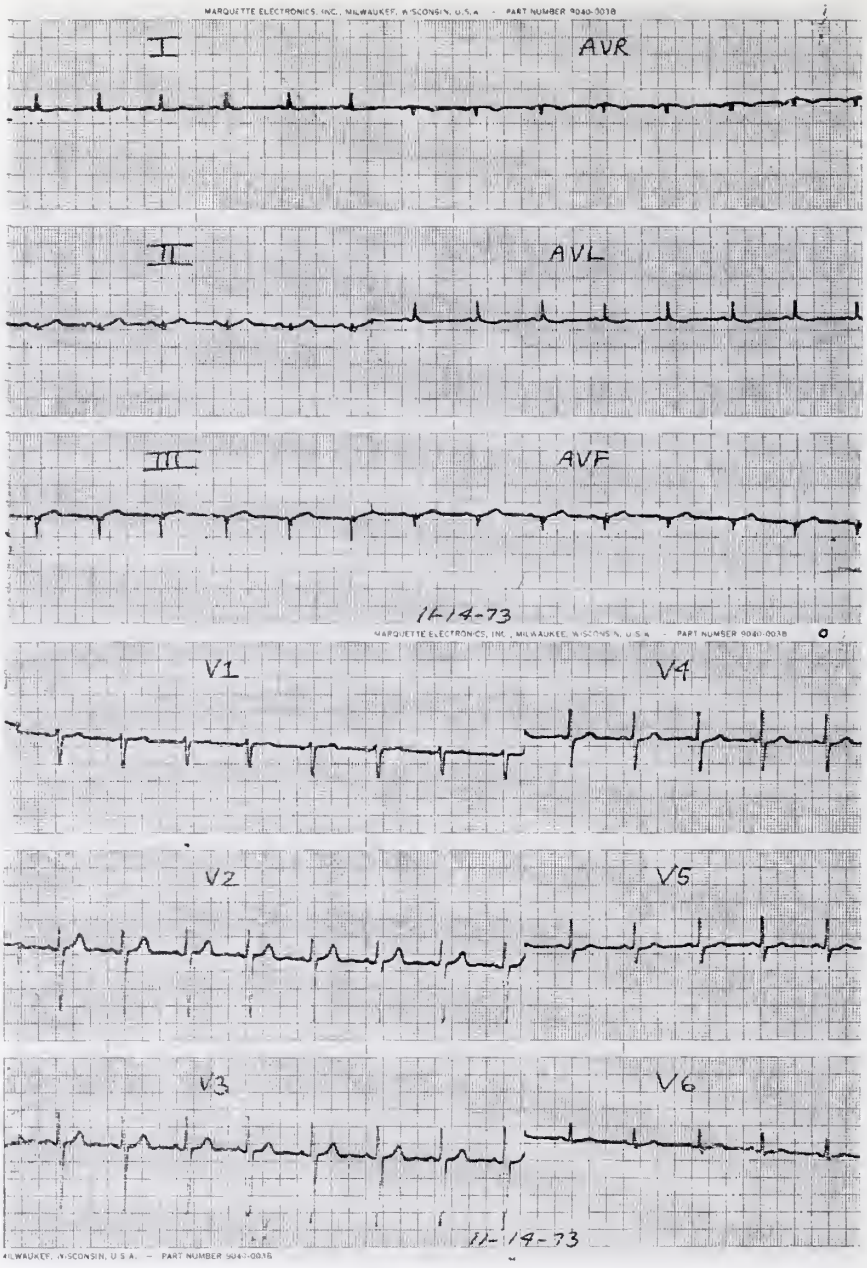
Figure 1



EKG Processing Center—University of Florida
This Interpretation Must Be Reviewed By A Physician
Patient No. 25188957
Date 11-9-73 Time 15 Hrs. 5 Min.
Normal Sinus Rhythm, Rate 65
Consider Pulmonary Disease
QRS Duration is Less Than Q15 Ms, and Largest Positive Deflection in V5 is Less Than .95 MV
Peak to Peak QRS in V6 is Less Than .6 MV
QRS Area is Negative in V4
Low QRS Voltage in Frontal Plane

INTERVALS IN MILLISECONDS					FRONTAL PLANE ANGLES IN DEGREES				
P-R	QRS	Q-T	T	P	QRS	P	T	J	QRST
140	95	369	157	98	-04	45	63	None	16x

Figure 2



EKG Processing Center—University of Florida
This Interpretation Must Be Reviewed By A Physician
Patient No. 25188957
Date 11-14-73 Time 9 Hrs. 37 Min.
Normal Sinus Rhythm, Rate 81
Low QRS Amplitude
Peak to Peak QRS Amplitude Does Not Exceed .6 MV in Any Limb Lead
Consider Pulmonary Disease
QRS Duration is Less Than 115 MS, and Largest
Positive Deflection in V5 is Less Than .95 MV
Peak to Peak QRS in V6 is Less Than .6MV
QRS Area is Negative in V4
Low QRS Voltage in Frontal Plane
Consistent With Inferior Infarction
(Q Duration is At Least 50 MS in Lead III) Plus
(Any Q Wave in Lead II IF R is Less Than .15 MV in Lead III) Plus
(Any Q Wave At Ieast 1 MM High and 20 MS Wide in AVF) Plus
(QRS Angle is Less Than 35 Degrees or Q in Lead III
Is Larger Than .5 MV) (Type II)
Q Duration is 50 MS or More in Lead AVF Plus Q is
More Than 20 MS in Lead II (Type I)
Warning, Infarction Statement May Be Incorrect
Because of Measurement Error, Check for Small R Waves Which
May Have Been Missed Because of Low QRS Amplitude in Frontal
Plane Leads
Warning, Infarction Statement May Be Incorrect
Because of Possible Measurement Error in Lead AVF

INTERVALS IN MILLISECONDS					FRONTAL PLANE ANGLES IN DEGREES				
P-R	QRS	Q-T	T	P	QRS	P	T	J	QRST
134	88	335	152	96	-24	15	92	None	05

Figure 3

near-perfect interpretive ability for the computer may lead some physicians to rely heavily on computer-generated reports for making a diagnosis. The physician in this case discarded a correct clinical diagnosis for this very reason. His clinical judgment yielded to the computer, and the patient initially received less than optimal care.

Distinction must be made between ECG interpretation and medical diagnosis. Many physicians caring for sick people in rural areas depend upon ECG interpretation for a medical diagnosis, even though such a diagnosis usually requires other information. Recent studies by Abbott and Scheinman[4] support previous reports[5] on the lack of sensitivity of the ECG in acute myocardial infarction. Thirty-four percent of the patients in their series with acute myocardial infarction had nondiagnostic electrocardiograms (no pathologic Q waves). Considered individually, the computer ECG interpretations in this case report were correct, and if incorporated into a study of computer reliability would fit nicely into the 96.7% correct diagnoses reported.[1] The diagnosis was wrong, however, and considered serially, the first two computer ECG interpretations were wrong. An error of this magnitude would be inexcusable for an electrocardiographer reviewing serial tracings; but this same error would probably go unnoticed in the usual statistical evaluation of computer reliability.

Comparison of a single ECG tracing with previous tracings is an essential part of clinical electrocardiography. Yet, commercially available computer systems either omit this step or offer it on a limited basis at increased cost. In our community hospital ECG department, 65% of interpreted ECG's must be compared with previous records. Omission of this important step in ECG interpretation was directly responsible for the problems illustrated by this case report.

Perhaps the most urgent need for prompt ECG diagnostic services at the community level is not for evaluating the patient with chest pain, but relates to the difficult problem of the recognition and management of complex arrhythmias. Crevasse and Ariet admit that complex arrhythmias are not adequately evaluated by the Bonner program.[1] Others have pointed out this deficiency in other programs.[6] Most physicians, however, have not been made aware of this deficiency by the proponents of computer-use. Until the technically difficult arrthythmia programs are created and tested clinically, the interpretation of arrthythmias must be performed by a physician.

Many computer ECG systems are being marketed in this area without noticeable concern for the effects of the output of these systems on patient care. Glowing claims of near-infallibility of these systems are frequent by those selling them; little is said about the limitations of the ECG as a diagnostic tool. Salesmen for computer ECG systems are offering a potential improvement in patient care only if the practitioner understands what he and his patient will receive. Used properly the computer system described by Crevasse and Ariet,[1] and others, may ultimately represent a significant advance in the care of patients with heart disease. This remains to be proven, however. If efforts are continued to sell the computer service to the physician, he should also be taught how to use it.

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▶ Drs. Riley and Langhorne, 14 West Jordan Street, Pensacola 32501.

The budget should be balanced, the treasury should be refilled, public debt should be reduced, the arrogance of officialdom should be tempered and controlled, assistance to foreign lands should be curtailed lest Rome become bankrupt. The mobs should be forced to work and not depend on government for subsistence.

Marcus Tullius Cicero, speaking to the Roman Senate

Mediastinoscopy

A Critical Review

J. A. Tobias, M.D.; M. A. Nesmith Jr., M.D., and R. E. Rawitscher, M.D.

Abstract: The two types of mediastinoscopy currently in use allow an exploration of regional lymphatic spread in carcinoma of the lung with little morbidity and mortality. The results in 64 patients are reviewed with an incidence of 30% positive biopsy and 18% false negative. In the light of current concepts of resectability in lung carcinoma, the results of routine preoperative mediastinoscopy provide valuable information, but must be evaluated as only one part of a total clinical picture.

The ideal preoperative evaluation of patients with carcinoma of the lung should detect those who are not surgically curable while not denying resection to any patient with a chance of cure. Over the past 25 years, several procedures have been devised of exploring the lymphatic circulation to detect spread outside the bounds of resection. Various techniques have evolved since introduction of scalene node biopsy by Daniels in 1949.[1] Upper mediastinal exploration was advocated by Harken and his associates in 1954.[2] Currently the midline pretracheal mediastinoscopy of Carlens[3] or the anterior mediastinal exploration as described by McNeill and Chamberlain[4] are widely used. Evidence published by Kirsh et al[5] has questioned whether this very proximal lymphatic exploration has not excluded some curable patients from resection since it permits biopsy of regional ipsilateral nodes which can potentially be encompassed by a radical resection. At the University of Florida College of Medicine and the Veterans Administration Hospital of Gainesville, we have recently embarked on a program of routine preoperative mediastinoscopy. The experience of the past year has led to a reevaluation of the clinical utility of routine mediastinoscopy in light of current concepts of resectability.

Clinical Material

All patients suspected of having carcinoma of the lung were considered candidates for mediastinoscopy. Those demonstrably inoperable because of metastases to liver, brain, bone, or other distant foci or deemed unresectable by bronchoscopic criteria were excluded. The anterior pretracheal route was used in those patients with hilar enlargement or peripheral lesions larger than 3 cm in diameter. Patients with lesions in the lung parenchyma smaller than 3 cm were not subjected to mediastinoscopy because of the very low yield of unsuspected positives.[6] In those patients with radiologic evidence of lymphadenopathy in the anterior mediastinum, approach through the bed of the second costal cartilage was used.

A total of 63 mediastinoscopies were performed between March 1, 1972 and March 1, 1973. The average age of the patients was 62 years and 86% were male. The main presenting symptoms were chest pain, weight loss, and hemoptysis. Analysis of symptomatology and findings indicates that our patient population is not significantly different from that in other reported series (Table 1). Hoarseness with left vocal cord paralysis or diaphragmatic paralysis on either side was not considered a contraindication to resection since both areas may be potentially encompassed by radical pneumonectomy. Sputum cytology was positive in 27% of all patients.

Table 1.

Symptoms	
None	7
Chest pain	29
Weight loss	27
Hemoptysis	17
Hoarseness	6
Other	10
X-ray Findings	
Normal	2
Location	
Hilar	31
Peripheral	24
Both	6
Side	
Right	26
Left	30
Bilateral	5
Sputum Cytology	
Negative	37
Suspicious	9
Positive	17

Results

Of the 63 mediastinoscopies, 58 were done by the pretracheal route, four by the anterior route, and one patient had mediastinoscopy by both routes. The procedure was routinely done under the same anesthesia as bronchoscopy and the average operating time for both procedures was 74 minutes. There was one operative death and a second patient had significant morbidity. The death occurred in a patient with known preexistent heart disease who had a myocardial infarction ten days after mediastinoscopy and so was probably not related to the operative procedure. One patient early in the series required emergency thoracotomy to control bleeding after an inadvertent biopsy of the myocardium. More careful aspiration with a long needle prior to biopsy of any structure has prevented the recurrence of this complication. To date, no patient has developed mediastinitis, pneumothorax, recurrent nerve injury, or other complications.

Thirteen patients were eventually proven to have benign disease. None of them had a positive biopsy for carcinoma at the time of mediastinoscopy. Eight patients required thoracotomy to establish a benign diagnosis, and five were proven benign by other means. Mediastinoscopy was not helpful. We have not accepted the finding of granuloma in a biopsy specimen obtained at mediastinoscopy as being necessarily indicative of benign pulmonary disease unless carcinoma was positively excluded because of the possible coexistence of benign disease and carcinoma, as occurred in one of these patients. Two of the patients had saccular aneurysms of the aortic arch when explored. Fortunately, neither was biopsied during mediastinoscopy.

Fifty patients had carcinoma (Table 2). Twenty-nine patients were not explored by thoracotomy. The seven patients with positive ipsilateral node biopsy all had ipsilateral nodes above the azygos vein on the right or the aortic arch on the left. In those patients not operated on because of oat-cell carcinoma, this diagnosis was obtained from biopsy at the time of bronchoscopy. In the five patients who were not operated upon because of distant metastases, all were discovered after mediastinoscopy.

Of the 21 patients who had thoracotomy, 12 were resectable giving a rate of 57%. Of the nine patients found to be unresectable, two were by reason of pleural involvement. These thoracotomies could not have been prevented by a technically better mediastinoscopy. However, seven patients were considered to be unresectable because of a tumor involvement in the areas potentially accessible to mediastinoscopy. One patient had a positive ipsilateral node biopsy at mediastinoscopy, was explored and found to be unresectable because of extensive mediastinal metastases. Four patients had hilar metastases extending to the periesophageal chain posterior to the trachea and were considered unresectable for this reason. This is an area which is not routinely explored in a mediastinoscopy done by the Carlens technique, but can potentially be reached. Two patients were unresectable because of tumor involvement of the aortic arch. Although this area potentially can be biopsied through the mediastinoscopy, because of our experience with aneurysms presenting in this area we have been reluctant to biopsy any structure clearly attached to the aorta.

TABLE 2.

- Patients with Carcinoma — 50
  - Thoracotomy — 21
    - Resectable — 12
    - Unresectable — 9
      - Pleural involvement — 2
      - Hilar involvement — 5
        - Positive mediastinoscopy — 1
      - Aortic involvement — 2
  - No Thoracotomy — 29
    - Positive mediastinoscopy — 14
      - Ipsilateral — 7
      - Contralateral — 5
      - Both — 2
    - Negative mediastinoscopy — 15
      - Oat-cell carcinoma — 4
      - Brain metastasis — 4
      - Liver metastasis — 1
      - Operative mortality — 1
      - Inadequate pulmonary function — 2
      - Refused surgery — 3

Discussion

Although carcinoma of the lungs spreads by all three routes available, hematogenous, lymphogenous and direct extension, the lymphatic route is most easily available for routine preoperative evaluation. Routine preoperative mediastinoscopy is recommended by many authors to select patients for thoracotomy. By this method, it is possible to raise the resectability rate at thoracotomy while lowering the operability rate in the total series. The procedure can be done with low morbidity and mortality provided one is judicious about biopsying unknown structures through the limited exposure available. In those patients who are not resectable for cure, certainly mediastinoscopy offers a means of demonstrating inoperability with low morbidity and mortality.

The key to safety in mediastinoscopy appears to be careful attention to technical details. Aspiration of any structure with a long cardiac needle through the mediastinoscope prior to biopsy will avoid biopsy of the aorta, pulmonary artery, myocardium, or azygos vein with resultant brisk hemorrhage. Saccular aneurysms of the aortic arch presenting as mediastinal masses in two patients did not fill with contrast material during aortography. This observation underlines the need for caution in biopsying any structure with transmitted pulsations even though blood may not be obtained at the time of aspiration.

Although mediastinoscopy can be done safely and information gained as to the extent of involvement of the regional lymphatic chain by carcinoma of the lung, the best way to utilize this information remains to be demonstrated. The two central issues are whether biopsy of a node involved by tumor will compromise a later resection, and what extent of lymphatic involvement is resectable for cure.

In carcinoma of the breast, for example, needle biopsy has been shown to result in tumor implantation along the needle tract in a significant percentage of instances. For this reason, excision of an incisional or needle biopsy tract has become standard surgical procedure when resecting most tumors. It has been demonstrated to be possible, however, to do needle biopsy of carcinoma of the lung without a demonstrable incidence of tumor implantation or a decrease in cure rate.[7] This suggests that tumors may differ in their ability to implant in tissues. The question—whether biopsy of a node involved by carcinoma of the lung followed by resection for cure will result in a lower cure rate due to local tumor implantation along the biopsy tract—remains to be answered.

The second question regarding the extent of regional lymphatic spread which can be resected for cure also is not answered at this time. Clearly, histologically similar carcinomas of the lung may differ widely in their biologic behavior. Some tumors may have extensive local invasion but not spread through the lymphatics or vascular route and be curable by wide local incision. The Pancoast tumor is an example. Other tumors may kill their hosts from brain or other distant metastases while remaining so small locally as to be impossible to detect on chest x-ray. With this range of biologic behavior, it is reasonable that hilar or mediastinal node involvement does not necessarily mean incurability in all patients. What is needed is a test to assess the aggressiveness of the tumor and the resistance of the host, and this is not currently available.

In the light of these considerations, mediastonoscopy appears as one of many ways of determining resectability in carcinoma of the lung. The results of mediastinoscopy must be evaluated as one part of an overall clinical picture. For example, a biopsy proven spread of lung cancer to areas that are not considered resectable routinely, such as the nodes above the azygos vein on the right side, might save the elderly patient with marginal pulmonary function an unrewarding thoracotomy. However, in a young patient with little mediastinal involvement, good pulmonary function and a well-differentiated tumor, resection might be undertaken. In this case, mediastinoscopy would provide valuable preoperative information allowing the radical resection to be planned.

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"A bad doctor treats symptoms; a competent doctor treats diseases; but a good doctor treats patients."

Sidney J. Harris
National Syndicate Columnist

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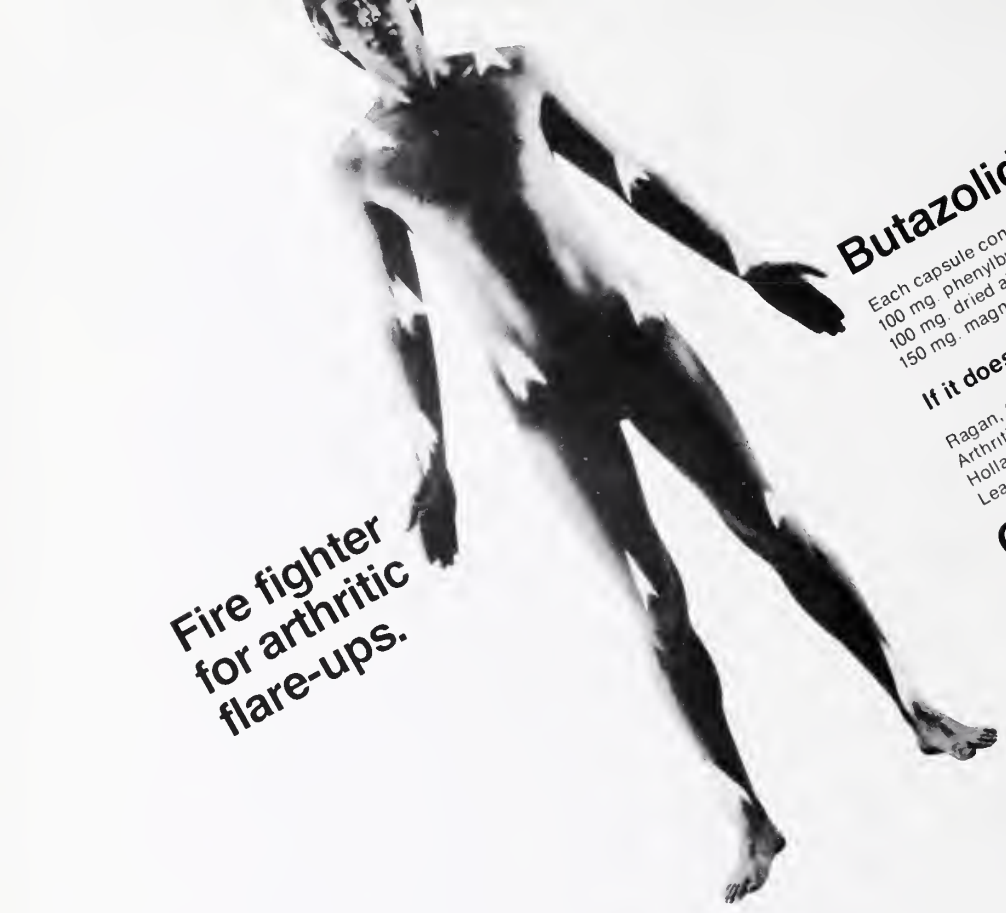

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Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications. Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Medical News

BACK TO THE PEDIATRIC DEPARTMENT . . . Gerold L. Schiebler, M.D., Chairman of the FMA Council on Scientific Activities and an Assistant Editor of *The Journal*, returned to his pediatric chair at the University of Florida College of Medicine, effective January 1.

Dr. Schiebler took leave of his academic post in November, 1973, to become the first Director of the Division of Children's Medical Services of the Department of H&RS, with headquarters in Tallahassee.

The 14-month period was "a very educational year for me," according to Dr. Schiebler. He said he was impressed by his colleagues and superiors in government, all of whom "gave me nothing but 100 per cent cooperation."

DR. MOYA HEADS ASA . . . Frank Moya, M.D., Chairman of Anesthesiology at the Mount Sinai Medical Center, Miami Beach, has been installed as President of the American Society of Anesthesiologists.

FIRST EDWARD R. ANNIS SCHOLARSHIP . . . Lo Kathleen Moss of St. Petersburg has been named the recipient for the first scholarship awarded Physicians Planning Service of Tampa in honor of Edward R. Annis, M.D.

The cash award of $500 will be made each year to an outstanding freshman at the University of South Florida College of Medicine. Dr. Annis, a Miami physician known throughout the world, is a former President of the American Medical Association and the World Medical Association.

ASSOCIATION ADMITS 10,000th MEMBER . . . The Florida Medical Association reached a historic milestone on December 19, 1974, when total membership reached 10,000 for the first time. The distinction went to Nieves Maria Zaldivar, M.D., a Cuban born pediatrician who became an FMA member through the Dade County Medical Association. Dr. Zaldivar, a 1971 graduate of the Mount Sinai School of Medicine of the City University of New York, is Assistant Professor of Pediatrics at the University of Miami School of Medicine.

DR. ANNIS IS CANDIDATE FOR RE-ELECTION . . . Jere W. Annis, M.D., Lakeland internist, is a candidate to succeed himself as a member of the American Medical Association Board of Trustees, subject to election at the Annual Meeting in Atlantic City, N.J., next June.

Dr. Annis, President of the Florida Medical Association in 1958, was first elected to an unexpired term on the AMA Board in 1971 and was subsequently elected to a full three-year term in 1972.

In a recent memorandum to AMA delegates and state medical society officers throughout the country, Florida AMA Delegation Chairman Francis T. Holland, M.D., Tallahassee, and FMA President Thad Moseley, M.D., Jacksonville, said of Dr. Annis:

"We believe Dr. Annis' record of careful, deliberative and impartial action on the Board, and as a member of several of its subcommittees speaks for itself, and that he should be continued in this responsible position during these trying times. He has the unqualified respect of the Board and more important, the confidence of the House."

9th NATIONAL SOCIOECONOMIC CONGRESS . . . will be held at the Regency Hyatt Hotel in Atlanta, April 25-26, under the sponsorship of the American Medical Association. Experts from medicine, the insurance industry, the public and government will participate. A $50 registration fee will be charged, and physicians attending will receive Category I credit for the AMA Physician's Recognition Award on an hour-for-hour basis. Additional information may be obtained by contacting: Division of Medical Practice, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with tha recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angionaurotic edema, giant urticaria and paralytic ilaus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropina sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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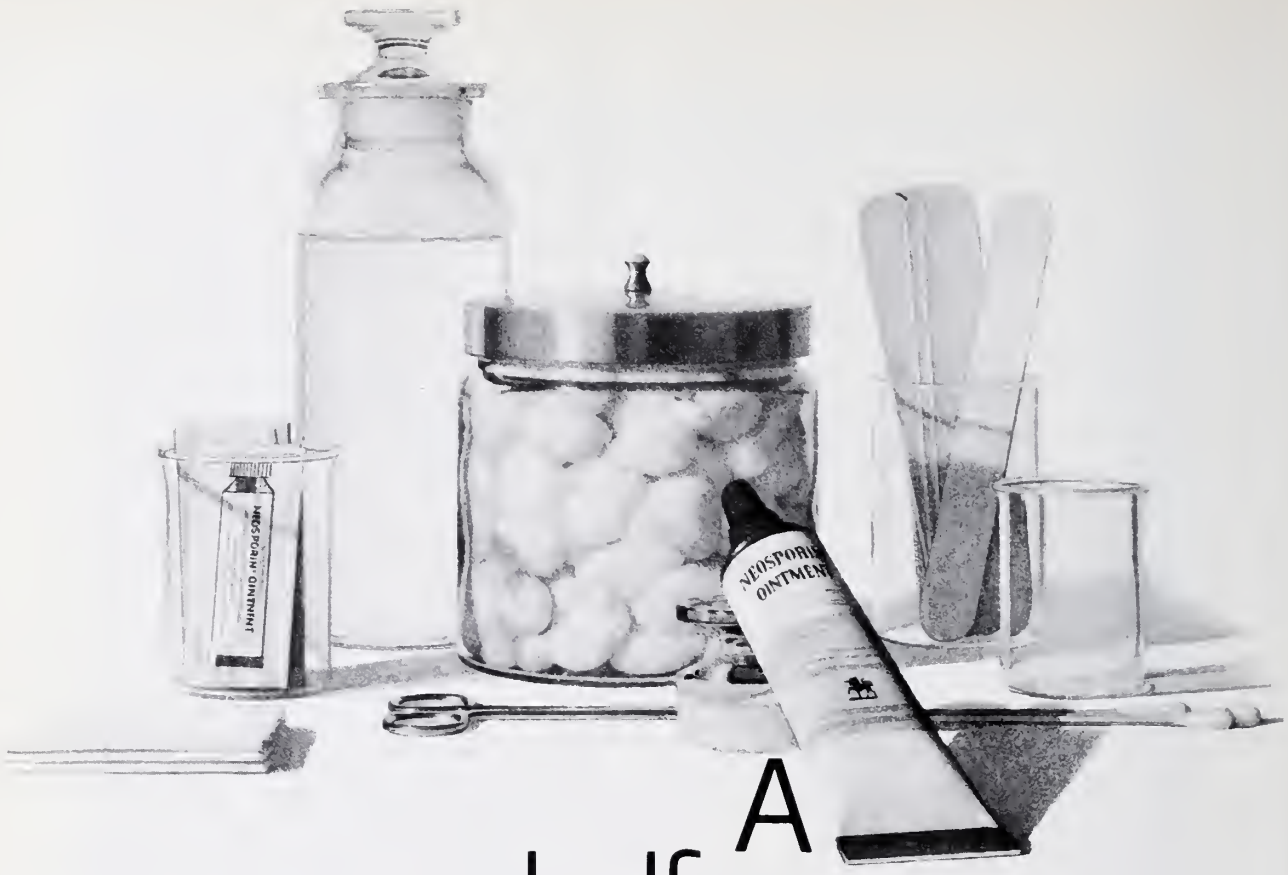

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Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.
Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of pe allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

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Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. **Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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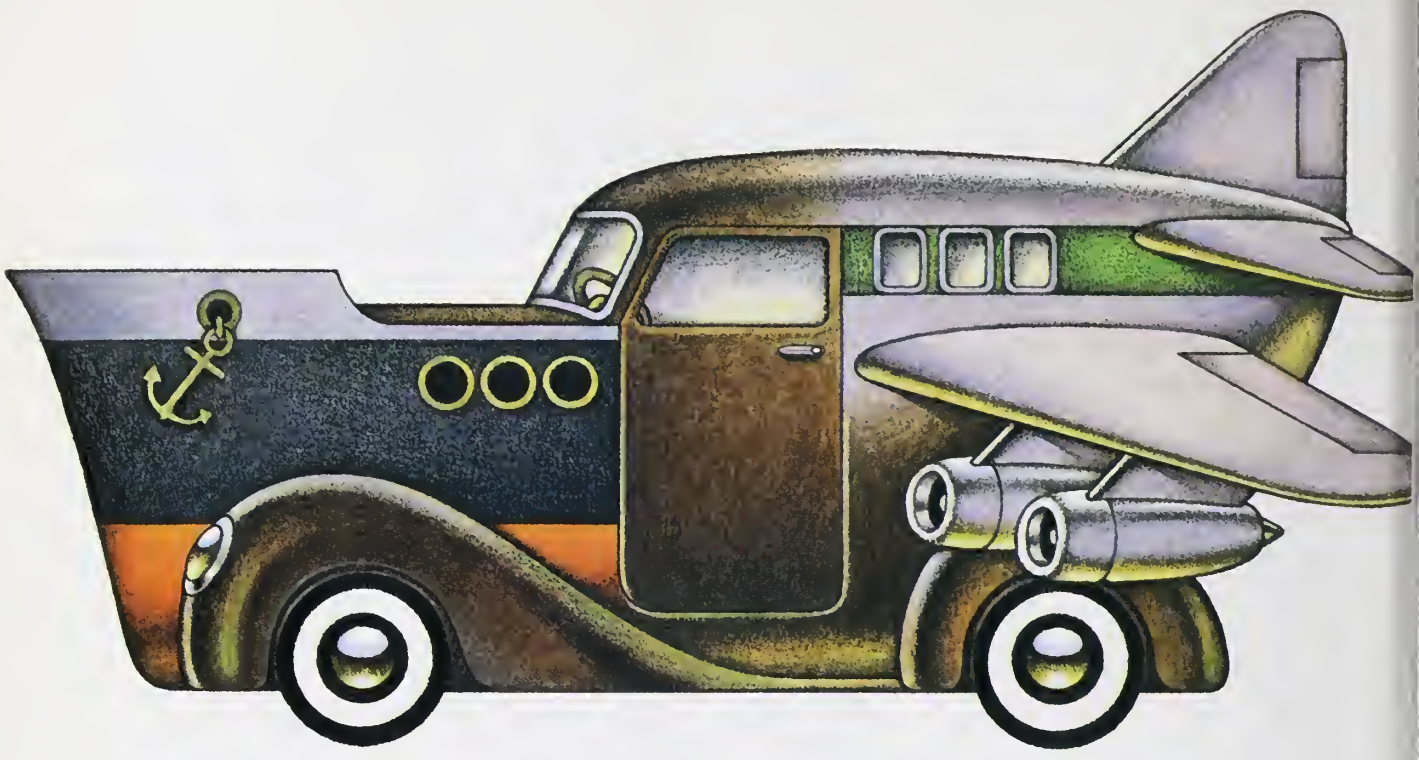

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Special Article

Health Services at City and County Jails, Stockades and Youth Detention Centers in Florida

WILLIAM R. STINGER, M.D.; BENJAMIN A. JOHNSON, M.D., AND WILSON T. SOWDER, M.D.

Although prisons and other detection facilities have been part of society for centuries, the inmates' health status has been of little concern and received little attention until recent years. The general public believes that immediate health needs are probably being met in one way or another, but details are vague. Goldsmith pointed out the lack of substantive data nationally on the quality and quantity of medical care available at correctional institutions.[1] After contacting several thousand prison system officials throughout the country, the American Medical Association and American Bar Association concluded that medical care is virtually nonexistent in many jails and barely adequate in hundreds more.[2]

In 1972 the Florida Division of Health and its component county health departments were authorized to inspect all city and county jails, stockades and youth detention centers. The major objectives were to identify existing health services and facilities, determine if health conditions were satisfactory and in compliance with applicable state standards, recommend any corrections or improvements, and develop a departmental system for periodic inspection and continuous evaluation. Dietary and environmental factors were also included.

Development of inspection teams was considered and this approach eventually may be employed. The consensus was that the initial survey would be best accomplished by independent evaluations of three major aspects of health care, i.e., personal health services, environmental conditions and nutritional status. This report summarizes the data on personal health services.

The Division of Health's committee devised a questionnaire for surveying all facilities which held prisoners for 24 hours or longer, thus defining a jail, stockade or youth detention center and eliminating smaller facilities primarily used for holding prisoners temporarily. Some questions were necessarily judgmental and subjective. A few called for a "yes" or "no" answer in situations that possibly were not always that clear cut. All inspections regarding personal health services were performed by medical personnel.

From November 1972 to January 1973 surveys of 228 facilities, 204 jails and 24 youth detention centers, were completed.

Adult Facilities

Adult facilities were considered separately from youth centers. The adult facilities were grouped into three categories according to census, i.e., under 25 inmates, 25-99 inmates, and 100+ inmates, and have been designated as small, medium size and large facilities in this report. One hundred fifty-two of the 204 jails, approximately 75% were small and housed about 10% of the total 7,536 inmates; 18 housed 4,885. Most small facilities are operated by municipalities and medium size and large facilities by counties. Only five facilities housed more inmates than their designed capacity. All were in the large category.

Over 20% of adult facilities had some type of identifiable medical facility but generally were found inadequate regarding space, equipment and laboratory capability. Approximately half of all institutions had first aid facilities only and nearly one fourth had neither an identifiable medical facility nor a first aid station. As expected, the latter situation was limited to the small institutions. Written medical policies and/or adequate medical records were present in approximately 30% of all institutions.

Approximately one third of all institutions regularly hold some type of sick call usually on a daily basis. It is conducted predominantly by nonmedical personnel. Only three facilities reported that an admission physical examination was

routinely performed on each inmate by medical personnel, but almost every institution reported that they made provision for examination by medical personnel when the inmate's condition or complaint warranted it. Less than 20% obtained a medical history on each inmate. Nearly three fourths reported that a physician was on call at all times.

Except in a few small jails, medications were available, supplied by the facility in most instances. In some cases the inmate's family also was allowed and/or expected to furnish them. Nonmedical personnel usually dispensed medications. Seven facilities allowed inmates to keep their own drugs. Storage arrangements were considered satisfactory in about 80% of the institutions. In three instances addictive drugs were among those unsatisfactorily stored.

Some type of dental service was available at approximately 85% of all institutions but usually was limited to emergency care. Those with no care available were almost all small facilities.

Most institutions utilize community health facilities to a great extent. Practically all had some arrangement for inpatient and/or outpatient hospital care. Over half stated that services were sometimes obtained at private physicians' and dentists' offices and at psychiatric facilities. Health department clinics were also used by nearly three fourths of the institutions. Where community health resources were inadequate, availability of medical and dental services was limited.

Nearly 43% of all institutions reported that mentally ill persons were held for varying periods before transfer to more appropriate facilities or release. Excluding small facilities, 65% hold such persons, indicating that this is still a very serious problem regardless of legislation and other support for the immediate treatment approach.

The alcoholic represents another problem which will become more significant in the near future in view of state legislation. Approximately 82% of all institutions, including all but one of the large facilities, hold such persons.

In the majority of cases treatment for acute drug addiction is provided within the jail or at some other detoxification facility, mainly hospitals. Three medium size and 11 small jails reported no treatment available, but an additional four medium and 23 small jails did not specify what detoxification facility was available. The questions were not designed to measure the total impact of drug abuse problems on the penal system, so the apparent capability of most institutions to treat or to make arrangements for the treatment of acute signs and symptoms of drug addiction should not be construed as adequate management of the entire problem in the jails.

There were 52 deaths among inmates of jails during the past year and 23 were attributed to suicide, 14 in small facilities. One additional death by suicide was reported in a youth detention center.

The surveyors reported the general level of medical care unsatisfactory in eight of the 18 large jails, 11 of the 34 medium size and 27 of the 152 small facilities. Half did not have a physician on call at all times, but all except two indicated that hospital emergency rooms were available. Seventeen had neither an identifiable medical facility nor a first aid station. A careful review of the "unsatisfactory" ratings failed to establish a consistent pattern or group of deficiencies to account for the opinions of various surveyors.

Youth Centers

The survey of the 24 youth centers indicated that half were small facilities with a census of under 25 persons, 11 were in the medium size category, and one housed more than 100 individuals. County authorities operated 21 and municipalities three. At the time of the survey, four facilities housed more people than their designed capacity.

Ten centers had some type of identifiable medical facility. With few exceptions, the clinical facilities generally were considered adequate regarding space, equipment, drugs, supplies and maintenance. An additional ten centers had first aid stations but four small ones had neither a clinic nor first aid station.

Approximately two thirds of the centers regularly hold some type of sick call usually on a daily basis and under supervision of a physician and/or nurse. Written medical policies and adequate medical records were present in most instances. Ten facilities reported routine admission physical examinations by medical personnel, and two thirds of the centers have a physician on call at all times. Hospital emergency room services apparently are available to all centers and patients frequently are referred to private physicians' offices, health department clinics, mental health centers and other community health facilities.

All centers had some arrangement for making prescription drugs and other medications available. No facility permitted patients to keep their own drugs. Nonmedical personnel were usually

involved in the dispensing procedure. In four centers drug storage was considered a problem.

Only emergency dental needs were being met in most instances. Restorative services and preventive dentistry were seldom available.

The majority of youth detention centers are forced to hold juveniles with possible mental disorders for varying periods of time before psychiatric evaluation and/or transfer to more appropriate facilities can be arranged. Four centers also reported that youngsters suffering from alcoholism were held. Mainly through utilization of general hospitals, treatment is available for acute drug addiction problems, but institutional and community resources are inadequate for the continued management of drug abuse cases.

The surveyors considered medical services satisfactory in 15 and unsatisfactory in nine centers.

Conclusion

The survey of 204 jails and 24 youth detention centers indicates that the level of health care services generally depends upon the health resources of the supporting community and the characteristics of its health care delivery system. Great differences exist in variety, quality, availability, and utilization.

Of major concern are the large number of nonmedical personnel who are making judgmental decisions on health matters which influence directly the quality and quantity of health care services rendered to the inmate population. Among inmates, problems related to alcoholism, drug abuses and mental illness are of great importance. The number who successfully commit suicide attest both to the significance of the mental health status of the inmates as well as the need for adequately trained personnel to screen those apprehended and detained.

This survey indicates a need to categorize jails and centers according to the purpose they serve in relationship to the inmate population, develop a health profile of the inmate population, and better define the health needs of this group. Precise criteria for the evaluation of health service programs do not exist and there is a need for several model programs.

References

1. Goldsmith, S. B.: Jailhouse Medicine—Travesty of Justice? HSMHA Health Services Reports 87:767-774 (Nov.) 1972.
2. Prison Health Care Found Poor, Am. Med. News 16:13 (Mar. 5) 1973.

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CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

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Editorials

Metrication, Here We Come

There is a real question regarding which system of measurement best serves our varied purposes — scientific, educational, commercial and military — whether the present United States Customary System or the International System of Units. If another system appears superior, is the degree of superiority great enough to warrant the inconvenience, confusion, and expense involved in making a change?

The uniformity of units of weight and measure plus the simplicity of the decimal system inherent in the metric system could lead to fewer errors and possibly clearer understanding in the practice of medicine and in contemplation, interpretation and communication of all sorts of quantitative data. It could encourage exchange of information among medical colleagues throughout the world and perhaps further the hope of universality among scientific disciplines. Too, as society changes the required units of measurement and need for accuracy change.

If standardized measures eliminate confusion between milligram and grain dosages or between cubic centimeter and dram measurements, patients are ultimate beneficiaries. Physicians are intermediate beneficiaries; their comprehension of data is improved and calculation and administration of medications simplified.

The metric system is acceptable geographically and has much to offer in medicine. Actually it is not quite the same system Talleyrand and the French National Assembly launched in 1790. Various modernizing additions and adjustments have been made; perhaps more can be anticipated from a future General Conference on Weights and Measures. Certain basic appeals remain the same; however. The meter, keystone of the system, is by reason of its natural rather than arbitrary definition invariable, infinitely reproducible, immune from destruction, and equally appropriate anywhere in the world. Units of length, area, and volume have an inherent relationship to each other (units of area and volume derive from units of length). The decimal system also lends itself admirably to a simplicity of nomenclature.

In the United States the metric system is used by the pharmaceutical industry and generally in a limited manner — 35 millimeter film, 100 meter race, and 250 milligram capsule. Probably this country will adopt more of it but not entirely relinquish elements of the United States Customary System which is based upon the English System. To be sure neither physicians nor patients are likely to make a complete change. Patients will continue to report temperatures in degrees Fahrenheit and weight changes in pounds.

If the physician, then, must be conversant with two systems of measurement, why is it simpler?

In many applications the metric system bestows no particular benefit, but in some instances there is an advantage in the decimal feature. It is easier to see the difference between 144 cm and 158 cm than between 4′8¾″ and 5′1″. Likewise, one is penalized by having a fluid measurement of so many gallons, quarts, pints, and ounces if he needs to perform any mathematical operation. He can see instantaneously what 2% of 4225 ml is but what is 2% of one gallon, one pint, and 11 ounces?

In medical journal articles, weight and measure should be recorded in metric units to facilitate understanding among medical colleagues around the world. Kilograms, meters, etc., are universally understood whereas feet and inches, pounds and ounces, etc., are not. A neighbor visualizes an object the size of a tangerine, weight of a golf tee, or height of a sunflower plant but these descriptions are imprecise and meaningless to someone who lives in a different area.

This Journal as other medical journals published in the United States finds persuasive reasons to adopt use of the International System of Units for its scientific reporting. In the September 1974 issue the Editor announced that beginning in January 1975 JFMA would gradually convert with weight and measure given in both metric units and the U.S. Customary. Beginning in January 1976 only metric measurements will be used.

John J. Benton, M.D.
Panama City

Editor's Note: The above was written on request by the author of a Letter-to-the-Editor raising the question of precision in an illustration in The Journal announcing a change to the metric system from its United States customary equivalent. The letter was well written and the logic so well developed that rather than publish the letter, an idea was conceived that an editorial be requested which appears worthy of publication.

The Metric System is Here

Despite foot-dragging by Congress on metric legislation many U.S. organizations, schools and businesses are beginning the conversion to the International Metric System of measurement. One reason for changing is that the import-export trade advantage to the U.S. would total $10 billion annually and since the U.S. is the only industrial nation in the world not on the metric system, changeover is inevitable. As it is already taking place, the only choice Congress now faces is that of allowing the shift to occur in a haphazard and costly way or to orchestrate it over a reasonable period of time at minimal cost.

Our present system of measurements was developed partly on the whim of English monarchs with an inch being established as the distance from the interphalangeal joint of the King's thumb to its tip, and the yard as the length from the nose of Anglo-Saxon King Edgar to the middle finger of his outstretched arm. It's easy to see how the ruler's foot became accepted as another unit of measurement and when it was noticed that its length was about 12 times that of the distal phalanx of his thumb, a fairly standard length was established. This appeared more logical than the original definition of a foot as "35 fat barleycorns from the middle of a mature ear placed end to end." From this developed the system we now use, which includes such units as a long ton of 2,240 pounds opposed to the short ton of 2,000 pounds, not to mention the register ton, the measurement ton, the wheat ton, the timber ton or the English water ton. Contrary-wise, the metric system, developed by the French Academy of Science, was precisely based on units of 10. While it was a century later before it was put into use by that nation, it is the decimal system on which our own currency is based.

Switching to metric won't affect the enjoyment of watching young ladies at the beach with measurements of 96-66-94 cm nor make it difficult to prescribe tetracycline, the newer tranquilizers, or synthetic analgesics, but it will be a little confusing to decide whether a patient with a temperature of 38.50 C has a significant fever. In the sports world, swimming and diving events will, as now, continue to take place on metric lengths and heights but it will be startling to hear the sportscasters saying "first down and 9.4 meters to go." When a friend asks how many kilometers per liter does your new compact get, it will take a little adjusting to think metric. Yet, if the U.S. fails to convert to metric as the above editorial urges us to do, America could miss the boat financially, industrially and scientifically for as "the new saying goes—a miss is as good as 1,500 meters."

"Managing the Change to Metric—A Report to the Nation on the Status of Metric Implementation" is the theme of the First Annual Conference and Exposition of the American National Metric Council to be held March 17-19 at the Washington Hilton Hotel, Washington, D.C. The National Metric Conversion Boards of Australia, Canada and the United Kingdom will share their experiences in managing the changeover.

C.M.C.

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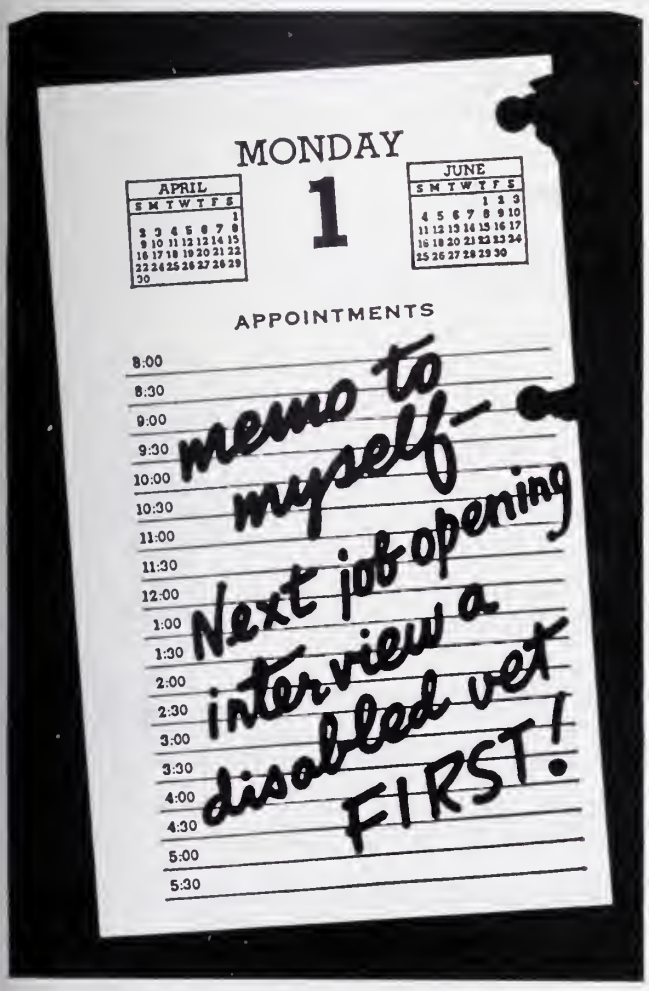

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ORGANIZATION

1975 Leadership Conference

Hoping to be more instructive and to attract more participants than last year, the 1975 FMA Leadership Conference and Seminar on Medical Legislation held in the Orlando Hyatt House near Kissimmee on January 25 and 26, at the final count was attended by medical society officers from 31 counties.

Opening the meeting Saturday morning, Thad Moseley introduced Dr. Robert Q. Marston, newly installed president of the University of Florida. He was followed by FMA council chairmen who explained the makeup of their teams and the workings of their activities. Speaking for the Judicial Council was Vincent P. Corso; for Medical Economics, James F. Richards; for Medical Services, Robert E. Windom; for Medical Systems, James L. Borland Jr.; for the Council on Scientific Activities, Gerold L. Schiebler, and for the Council on Specialty Medicine, Frederick C. Andrews.

During a complimentary buffet luncheon, Thad Moseley, with frightening facts and figures, urged us to use the term "professional liability" rather than "malpractice," when discussing that expensive form of insurance. In a question and answer period he explained that physicians could not self-insure themselves at reasonable premiums because of ever-increasing settlements, and that organized medicine is seeking legislative remedies in every state for immediate relief of the critical issue as well as long-range solutions to the liability problems facing physicians and their patients.

After lunch, John N. Carlson described means of improving membership participation and asked those in the audience to give him their suggestions. If this required changing the By-Laws he recommended that the House of Delegates be asked to change them.

Later, John Terry, chairman of the Committee on County Medical Society Presidents, expressed concern about the lack of information flow throughout the state. Heading a panel of presidents of county medical societies, he stated that often small county societies just don't know what's going on. He suggested that more information from the Board of Governors be passed on to every member, employing the Journal and other means. The discussion which followed gave anyone in the audience an opportunity to present their gripes about FMA activities. As President, Thad Moseley had a forum to present his opinions and gain a vote of confidence from those present. He is to be commended for spearheading such a meeting stimulating participation by the various county societies.

County medical society presidents, Pedro Greer of Dade, Robert Johnson of Capital and Harold Williamson of Hillsborough explained their solutions to some of the local problems plaguing them. One innovative method of neutralizing the adverse press coverage which medicine so often receives is a regular scheduled appearance of local physicians on local television programs.

Sunday morning, the FMA Legislative Seminar saw Irving Essrig presiding. Vernon Astler discussed the FMA legislative efforts for 1975 with professional liability having first priority. James Perry, new chairman of the Council on Legislation and Regulations, introduced a panel including Richard Hodes, a Tampa anesthesiologist and member of the state legislature; Thad Moseley, FMA president; James C. Rinaman Jr., Attorney-at-Law and David McClain, state senator from District 21.

A coffee break was followed by Ed Haskell, president of FLAMPAC, who gave an interesting outline of its activities. Lou Murray, chairman of the Committee on National Legislation discussed our nationwide goals. Following, Jim Foristel from the AMA Washington office told us that Paul Rogers is a friend of medicine, and then gave

his opinion of the possibility of various pieces of legislation being passed into law during this session.

All in all, this 17th annual conference was a meeting that you should have attended. It was educational to talk to officers of other county societies and learn how they solve problems; to hear some of the experiences of our own professional liability program and to learn about the makeup of FMA councils and committees. It was inspirational to see our elected officers intelligently debate policies and field questions from the audience. It was heartwarming to see old friends and exchange greetings with new acquaintances from around the state. If you missed it, you are the loser, but you can find out more about what went on by contacting your own county society president or secretary and asking him to give you the details.

C.M.C.

Doctor, Mark These Dates on Your Calendar:

April 23-27, 1975

101st Annual Meeting

Florida Medical Association

Americana Hotel

Miami Beach

IMPORTANT

The exhibit hall will be open at noon on Wednesday, April 23. Please have your art exhibits for the Woman's Auxiliary Annual Benefit Art Show registered and on display by 3:00 p.m. Judging will be done on WEDNESDAY, after 4:00 p.m.

Schedule of Activities

101st Annual Meeting
Florida Medical Association
April 23-27, 1975, Miami Beach

WEDNESDAY, APRIL 23

10:00 a.m.—General and Delegates Registration (Foyer/Exhibit Hall)
1:00- 4:15 p.m.—FMA Scientific Section on Internal Medicine (Medallion)
4:30 p.m.—FMA First House of Delegates (Bal Masque)
5:30 p.m.—Blue Shield Board Meeting (Eastward)

THURSDAY, APRIL 24

8:00 a.m.—Blue Shield Annual Meeting (Medallion)
10:00 a.m.—Reference Committee I (Westward II & V)
10:00 a.m.—Reference Committee V (Bal Masque)
10:30 a.m.—Reference Committee II (Pan American)
10:30 a.m.—Reference Committee IV (Eastward)
11:00 a.m.—Reference Committee III (Medallion)
1:30- 5:00 p.m.—Scientific Sections
4:00 p.m.—Florida Physicians Association Board of Directors Meeting (Pan American)
5:30- 7:00 p.m.—Scientific Sections
8:30- 4:30 p.m.—Visit Exhibits

FRIDAY, APRIL 25

8:30-10:45 a.m.—Scientific Sections & Specialty Groups
8:30- 4:30 p.m.—Visit Exhibits
11:00 a.m.—General Session (Baldwin Lecture) Guest Speaker: C. Rollins Hanlon, M.D., Director, American College of Surgeons, Chicago (Medallion)
12:15- 2:00 p.m.—Auxiliary & Flampac Luncheon (Medallion/Bal Masque)
2:00- 5:30 p.m.—Scientific Sections
5:00 p.m.—Florida Physicians Association Annual Meeting (Pan American)
6:30- 7:30 p.m.—President's Reception

SATURDAY, APRIL 26

8:30-12:30 p.m.—Specialty Groups and Scientific Sections
8:30- 3:00 p.m.—Visit Exhibits
1:00- 2:45 p.m.—Specialty Groups and Scientific Sections
3:00 p.m.—Second House of Delegates (Bal Masque)
Special guest speaker — Hon. Paul Rogers(D), U.S. Representative

SUNDAY, APRIL 27

9:00 a.m.—Third House of Delegates and Election of Officers (Bal Masque)

Annual Meeting Scientific Program Adds 31st Section

A Symposium on Obesity has been added to the scientific program for the 101st Annual Meeting of the Florida Medical Association at the Americana Hotel in Bal Harbour next month.

According to Program Chairman Yank D. Coble Jr., M.D., Jacksonville, the 2½-hour session will begin at 8:15 a.m. on Friday, April 25, under the co-sponsorship of the Florida Endocrine Society and the Florida Gastroenterologic Society. It will be supported by a grant from Weight Watchers International, Inc.

The obesity program brings to 31 the number of approved scientific sections that will be conducted during the Annual Meeting.

Dr. Coble also announced that a two-hour audio-visual program on "Interpreting Heart Sounds" will be shown several times during the meeting. It is approved for two hours of mandatory credit under the FMA Continuing Medical Education Program and for Category I Credit for the American Medical Association Physician's Recognition Award, and is supported by Roche Laboratories of Nutley, N.J.

It is possible for FMA members to earn up to 22 hours of mandatory credit under the mandatory education program by attending the Annual Meeting scientific sessions, Dr. Coble said.

In addition to the lecture program, the Committee on Continuing Medical Education has approved 25 educational and scientific exhibits for display in the Exhibit Hall.

The bulk of the scientific program was published in the February issue of *The Journal*. Following are program additions and changes since the February issue was published:

THURSDAY, FRIDAY and SATURDAY—APRIL 24-26

Interpreting Heart Sounds

This two-part, two-hour audio-visual program was developed under the guidance of the Committee on Special Teaching Demonstrations of the AMA Council on Scientific Assembly and was presented at the 1974 Clinical Convention of AMA at Portland, Ore. It concentrates primarily on the auscultation aspects of heart sounds, including a discussion of the underlying physiology of various abnormalities.

PART I (ABNORMALITIES OF THE FIRST AND SECOND HEART SOUNDS) will be shown at 8:30 a.m., 9:30 a.m., 10:30 a.m., and 11:30 a.m. on Thursday. Friday and Saturday. It includes:

—The normal heart sounds with physiologic splitting on respiration

—Alterations of intensity of the first heart sound

—Alterations of intensity of the second heart sound

—Fixed splitting of the second heart sound

—Variation in intensity of the first heart sound

—Paradoxical splitting of the second heart sound

—Wide variable splitting of the second heart sound

PART II (EXTRA HEART SOUNDS OTHER THAN MURMURS) will be shown at 12:30 p.m., 1:30 p.m., 2:30 p.m., and 3:30 p.m. on Thursday and Friday; and at 12:00 noon, 1:00 p.m., and 2:00 p.m. on Saturday. It includes:

—Nonejection clicks

—Atrial (S_4) gallop

—Ventricular diastolic (S_3) gallop

—Summation (S_3 and S_4) gallop

—Variant third sounds

—Ejection sounds

—Opening snaps

THURSDAY EVENING—APRIL 24

GENERAL SESSION ON PROFESSIONAL LIABILITY INSURANCE

(Co-sponsored by FMA Committee on Continuing Medical Education)

Thursday—3:30 p.m. to 7:00 p.m.

Moderator:

Robert E. Zellner, M.D., Orlando, former Board Chairman, Blue Shield of Florida, and Past President, Florida Medical Association

Panelists:

For the Insurance Industry: Leyton B. Hunter, President, The London Agency, Atlanta, Ga.

For the Plaintiff's Bar: J. B. Spence, Esq., Miami

For the Defense Bar: James C. Rinaman Jr., Esq., Marks, Gray, Conroy & Gibbs, Jacksonville

FRIDAY MORNING—APRIL 25

SYMPOSIUM ON OBESITY

(Co-sponsored by Florida Gastroenterologic Society and Florida Endocrine Society)

Friday—8:30 a.m. to 10:45 a.m.

Yank D. Coble Jr., M.D. Jacksonville
Program Chairman

"Etiology and Implications," Theodore Van Itallie, M.D., Professor and Chairman, Department of Medicine, St. Luke's Hospital, New York, N.Y.

"Emotional Aspects and Behavioral Modification in Obesity," Henry Jordan, M.D., Professor of Psychiatry, University of Pennsylvania School of Medicine, Phiadelphia

"Diet Gimmicks and Weight Rip-offs," Philip L. White, M.D., Director, Department of Foods and Nutrition, American Medical Association, Chicago, Ill.

"Is There a Surgical Approach to Obesity?" Edward R. Woodward, M.D., Professor and Chairman, Department of Surgery, University of Florida College of Medicine, Gainesville

"Management of Obesity," William H. Sebrell, M.D., Professor Emeritus and Chairman, Institute of Human Nutrition, Columbia University School of Medicine, New York, N.Y.

(One other speaker to be announced)

FRIDAY AFTERNOON—APRIL 25

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday—1:45 p.m. to 5:15 p.m.
Emmet F. Ferguson Jr., M.D., Jacksonville
Program Chairman

"Voiding Problems following Ano-Rectal Surgery, Consideration and Management," Walter W. Hamilton, M.D., St. Petersburg

(Title change only; all other speakers and papers as listed in February)

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday—1:30 p.m. to 5:00 p.m.

Hueston C. King, M.D., Miami
Program Chairman

"A New Technique for Voice Rehabilitation of the Laryngectomee," Stanley Taub, M.D., New York, N.Y.

(Title change only; all other speakers and papers as listed in February)

SATURDAY MORNING—APRIL 26

SECTION ON ORTHOPEDIC SURGERY

(Co-sponsored by Florida Orthopedic Society)

Saturday—8:30 a.m. to 12:30 p.m.

Jaime M. Benavides, M.D., Key West
Program Chairman

"Spinal Deformities, Central Florida, 1975," Joseph C. Flynn, M.D., Orlando

(Title change only; all other speakers and papers as listed in February)

SECTION ON OBSTETRICS & GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

Saturday—10:00 a.m. to 12:00 noon

Henry L. Wright, M.D., Boca Grande
Program Chairman

"Asthma and Pregnancy," Paul Gluck, M.D., Resident in Obstetrics and Gynecology, University of Miami School of Medicine, Miami

"Complications of Fetal Monitoring," Robert Ouellette, M.D., and Luis Fernandez-Rocha, M.D., University of Miami School of Medicine, Miami

(Session will begin at 10:00 a.m. instead of 9:00 a.m. Speakers listed above are in addition to those announced in February)

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday—9:00 a.m. to 10:30 a.m.

Walter R. Gilbert Jr., M.D., Jacksonville
Program Chairman

Revised Program

"Keratoconus," Antonio R. Gasset, M.D., Assistant Professor of Ophthalmology, University of Florida College of Medicine, Gainesville

"The Diabetic Retinopathy Study—Updated Data," Guy O'Grady, M.D., and George Blankenship, M.D., Assistant Professors of Ophtbalmology, University of Miami School of Medicine, Miami

"Surgical Correction of Ptosis," Richard R. Tenzel, M.D., Clinical Assistant Professor of Ophthalmology, University of Miami School of Medicine, Miami

Physicians desiring up-to-date program information should contact Mr. Edward D. Hagan at FMA Headquarters (Telephone (904) 356-1571) between 8:30 a.m. and 4:30 p.m., Monday through Friday.

Scientific and Educational Exhibits

Grand Ballroom

April 24-27, 1975

A-B "The Evaluation and Treatment of Hydrocephalus"—Homer D. Kirgis, M.D., and C. Harrison Snyder, M.D., Ochsner Clinic, New Orleans, La.

C-D "Florida Kidney Transplant Network"—Florida Kidney Disease Council.

E "Medical Examiners Program of Florida: A Closer Look at Death and Life"—Florida Medical Examiners Commission and Florida Division of Health.

F "Anti-Smoking Exhibit"—Manuel Viamonte Jr., M.D., and Maria Viamonte, M.D., Miami Beach.

G "Nurse Midwifery"—Florida State Council on Nurse Midwifery.

H "Voluntary Health Agencies"—Florida Voluntary Health Association.

J "Florida Perinatal Intensive Care Program"—Richard J. Boothby, M.D., and James Werba, M.D., Jacksonville.

K "The Twentieth Medical Specialty: Family Practice"—Florida Academy of Family Physicians.

L "Cancer Information Service—Dial Access System"—Southern Medical Association.

M "Automated Medical Record System in Family Practice"—H. B. Curry, M.D.; S. H. Schuman, M.D.; R. Schneeweiss, M.D; E. G. Haskell, M.D., and Mr. Don James, Charleston, S.C.

N "Mohs Chemosurgery for the Treatment of Recurrent Cancer of the Skin"—Henry Menn, M.D., Miami.

O "Silicone Subdermal Implants for Facial Reconstruction"—Mutaz B. Habal, M.D., Gainesville.

P "Calcifications in the Neck: A Spectrum of Normal to Pathological"—Lawrence R. Muroff, M.D., Tampa, and William B. Seaman, M.D.

Q "Midline Epidural Craniectomy—A New Procedure"—Mason Trupp, M.D., Tampa.

R-S "Non-Invasive Cardiac Evaluation with Radionuclides"—R. R. Sankey, M.D.; D. D. Watson, M.D.; P. J. Kenny, M.D., and A. J. Gilson, M.D., Miami.

T "Hemodynamics of Stress-Testing in Angina Pectoris"—Eugene J. Thompson, M.D., Brooklyn, N.Y.

U "Breast Reductions"—Thomas J. Zaydon, M.D.; Phillip T. George, M.D., and Ian D. Thompson, M.D., Miami.

V "Computerized Axial Tomography of the Brain: Comparison with Other Modes of Study in Selected Cases"—Donald Hansard, M.D.; Charles Bianco, M.D.; George Bank, M.D., and Charles Williams, M.D., Tallahassee.

W "Decreasing the Recidivism Rate of Chronic Schizophrenic Patients: The State Hospital and the Community"—Celina Dachtera-Bobowski, M.D., Chattahoochee.

X "Total Reconstruction of the Ear"—C. N. Kitsos, M.D., Miami Shores.

Y "Surgical Management of Ascending Aortic Aneurysms"—R. Rawitscher, M.D.; L. Botero, M.D., and G. Daicoff, M.D., Gainesville.

Z-AA "Scope of Plastic Surgery Including Rejuvenation of the Aging Face"—Florida Society of Plastic and Reconstructive Surgeons.

BB "Therapy With Patient and Therapists Under Hypnosis"—Abelardo Pena-Ramos, M.D.; Martin Lazoritz, M.D.; Coleen Cone, and Lesile Gilbert, Gainesville.

CC "A Simple Mechanical Approach to Pseudofolliculitis Barbae"—Bernard H. Cohen, M.D., Leonard A. Lewis, M.D., and Sorrel S. Resnick, M.D., Miami.

DD-EE "Cardiac Pacemakers"—James R. Jude, M.D.; Irwin B. Boruchow, M.D., and Ramanuja N. V. Iyengar, M.D., Miami.

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NINTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.).
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 3, 1975.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Americana Hotel no later than 4:00 p.m. Wednesday, April 23. Shipped entries will be refused.
8. All entries must remain on exhibition until 3:00 p.m., Saturday, April 26. They MUST be picked up between 3:00 and 4:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 4:00 p.m., Saturday, April 26.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc. Size: _____(H) X _____(W) To be hung on wall.

( ) B. Graphics. Include pen and ink, charcoal, photography, etc. Size: _____(H) X _____(W).

( ) C. Crafts. Include sculpture pottery, ceramics, mosaic, weaving, jewelry, etc. Size: _____(L) X _____(D) X _____(H)

( ) I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award" will be given and the winning entry will he used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

WA-FMA ART SHOW
c/o Mrs. William F. Hogan
2861 N. E. 29 Street
Fort Lauderdale, Florida 33306

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally.

We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 3, 1975

Judging will take place beginning at 3:00 p.m. on Wednesday

MEETINGS

Approved by FMA Committee on Continuing Medical Education

MARCH

▶ Continuing Education in Contemporary Medicine and Surgery, Mar. 2-7, Americana Hotel, Miami Beach. For information: American Soc. of Contemporary Medicine & Surgery, 40 N. Michigan Ave., Chicago 60602

3rd Annual Postgraduate Seminar in Emergency Medicine, March 5-9, Hyatt House, Miami Beach. For information: John Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Marco Island Cardiology Seminar, Mar. 2-4, Marco Beach Hotel, Marco Beach. For information: J. A. Hinckley, Box 11083, Richmond, Va. 23230

Updating the Management of Leukemias or Lymphomas, Mar. 6, Biscayne Medical Center*

Urology—Selected Topics for the Practitioner, Mar. 6-8, Hilton Inn, Gainesville**

Third Annual Postgraduate Seminar in Emergency Medicine, Mar. 6-9, Hyatt House, Miami Beach. For information: John F. Davison, M.D., 1200 N.W. 10th Ave., Miami 33136

Postgraduate Seminar in Neurology, March 10-14, Fontainebleau Hotel, Miami Beach*

Hormones and Cancer, March 10-14, Americana Hotel, Miami Beach*

Hypertension, Diabetes and Hyperlipidemia in Childhood, March 11-14, Americana Hotel, Miami Beach*

Cardiovascular Investigations With Radionuclides, Mar. 12-16, Miami Beach Hyatt House**

Annual Postgraduate Course in Pediatric Allergy, Association of Convalescent Homes for Asthmatic Children, Mar. 12-14, Americana Hotel, Miami Beach

Pediatric Surgical Postgraduate Course, Mar. 13-14, Variety Children's Hospital, Miami. For information: W. T. Brown, M.D., 6125 S.W. 31st St., Miami 33155

"Nephrology and Hypertension," Mar. 15-16, St. Vincent's Medical Center, Schultz Auditorium, Jacksonville

Clinical Radiology Seminar, March 18-22, Hyatt House, Miami Beach*

Systemic Metabolic and Hormonal Effects of Cancer, Mar. 18, Hospital Trailer, Martin Memorial Hospital, Stuart*

Seventh Teaching Conference in Clinical Cardiology, March 19-22, Sheraton Four Ambassadors Hotel, Miami*

Topics in Internal Medicine, Mar. 20-22, Gainesville Hilton, Gainesville**

Hematologic Complications of Cancer and Allied Diseases, Mar. 21, Auditorium, Parkway General Hospital, N. Miami Beach*

Obstetric & Pediatric Anesthesia Seminar, Mar. 21-23, Diplomat Hotel, Hollywood. For information: Frank Moya, M.D., Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Eighth Annual Instructional Course in Surgery of the Hand, March 21-23, University Hospital, Jacksonville. For information: Ira M. Dushoff, M.D., 824 Margaret St., Jacksonville 32204

Hypertension, Diuretics and Renal Disease, March 24-25, Sheraton Four Ambassadors Hotel, Miami*

Radiation Oncology: Indications for and Treatment of Cancer Patients, Mar. 27, Assembly Room, Florida Hospital, Orlando*

APRIL

Clinical Cardiology for the Practitioner, Apr. 3-4, Hilton Inn, Gainesville**

Seminar Session, Department of Anesthesiology, Apr. 7-11, University of Florida College of Medicine, Gainesville**

Regional Block in Modern Day Surgery, Apr. 7, University of Florida, Room M-523, Gainesville**

Effect of Concentration of Local Anesthetic Agents and Epinephrine on Uptake, Apr. 8, University of Florida, Room M-523, Gainesville**

The Comparison of Bupivacaine and Etidocaine for Vaginal Delivery, Apr. 10, University of Florida, Room M-523, Gainesville**

Fourth Annual Consecutive Case Study Conference, Apr. 11-12, Ponce De Leon Motor Lodge, St. Augustine. For information: George A. Anderson, M.D., 2005 Riverside Avenue, Jacksonville 32204

Fracture Bracing Workshop, Apr. 12-13, Miami*

Courses of Instruction in Coronary Care, Apr. 14-19, Jackson Memorial Hospital, Miami*

New Trends in Cancer Chemotherapy, Apr. 15, Hospital Trailer, Martin Memorial Hospital, Stuart*

▶ Geriatric Medicine 1975, Apr. 16-17, Sutton Beach Hotel, Miami. For information: American Geriatrics Soc., 10 Columbus Circle, New York 10019

Postgraduate Seminar on Arthritis and Related Diseases, Apr. 18-20, Thunderbird Motor Hotel, Jacksonville. For information: Louis M. Sales, M.D., 2522 Oak Street, Jacksonville 32204

Clinical Management of "The Poor Risk Patient," Apr. 19-20, Galatea Inn, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" St., Pensacola 32501

15th Workshop in Electrocardiography, Apr. 24-28, Tides Hotel, Redington Beach St. Petersburg. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

Program for Foreign Medical Graduation, Apr. 28 & July 24, Sheraton Four Ambassadors Hotel, Miami Beach*

MAY

25th Annual Postgraduate Seminar, May 1-3, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

An Intensive Day in Intensive Care, May 3, VA Hospital, Miami*

Seminar Session, Department of Anesthesiology, May 5-9, University of Florida College of Medicine, Gainesville**

Multidisciplinary Approach to Management of Head and Neck Cancers, May 9-10, Auditorium, St. Augustine General Hospital, St. Augustine*

Family Practice Review Program, May 12-16, Gainesville Hilton, Gainesville**

The Anxieties of Doctors, May 15, Baptist Hospital, Pensacola. For information: Claude L. Brown, M.D., 176 Louiselle St., Mobile, Ala. 36607

Master Approach to Cardiovascular Problems, May 15-17, Walt Disney World, Orlando*

5th Annual Radiotherapist Clinical Research Seminar, May 15-17, Flagler Inn, Gainesville**

Radiation Oncology, Indications for and Treatment of Cancer Patients, May 16, Auditorium, Parkway General Hospital, N. Miami Beach*

The Spinal Cord Injured Patients, May 16, Miami*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami. Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

Medical News

DR. NELSON ZIVITZ DIES . . . Nelson Zivitz, M.D., Miami Beach allergist who served on the FMA Judicial Council and was Chairman of the important Membership and Discipline Committee for several years, died two days before Christmas. In the 1950s, he held several offices in the Dade County Medical Association, including the presidency.

MIAMI BEACH GETS SMA MEETING . . . The 22,000-member Southern Medical Association has announced it will conduct its 1975 Scientific Meeting in Miami Beach, November 16-19.

OB.-GYN. SOCIETY ELECTS . . . The Florida Obstetric and Gynecologic Society installed H. L. Wright, M.D., of Boca Grande, as its President during its winter meeting at Tarpon Springs in December. He succeeds William T. Patton, M.D., of Pensacola.

Other new officers installed include: William H. Kirkley, M.D., Fort Lauderdale, President-Elect; and George N. Lewis, M.D., Tallahassee, Secretary-Treasurer (second term).

DERMATOLOGISTS ELECT FLORIDIAN . . . Morris Waisman, M.D., of Tampa, was elected to the Board of Directors of the American Academy of Dermatology during the group's annual meeting in Chicago in December. Dr. Waisman is Clinical Professor of Medicine at the University of South Florida College of Medicine.

INDUSTRIAL MEDICS ELECT . . . Sam R. Burnett, M.D., Daytona Beach, has been installed as President of the Florida Industrial Medical Association.

Eugene L. Horger, M.D., Boca Raton, was named President-Elect, and Bruce Bennett, M.D., Miami, and Joseph A. Baird, M.D., Belleair Beach, were elected Vice President and Secretary-Treasurer, respectively.

MEDICO-LEGAL PROGRAM AT GAINESVILLE . . . The Colleges of Medicine and Law at the University of Florida are developing a teaching program for medical and law students aimed at increasing appreciation of the challenges, ethics and interrelationships of the two professions. Director of the program is Walter Probert, Professor of Law. Teachers from both colleges will participate.

FAMILY PRACTICE EXAMINATIONS . . . The American Board of Family Practice will conduct certification examinations on November 1-2, 1975, in five cities. Physicians wishing to take the examination must apply by June 15, 1975.

Information may be obtained from Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

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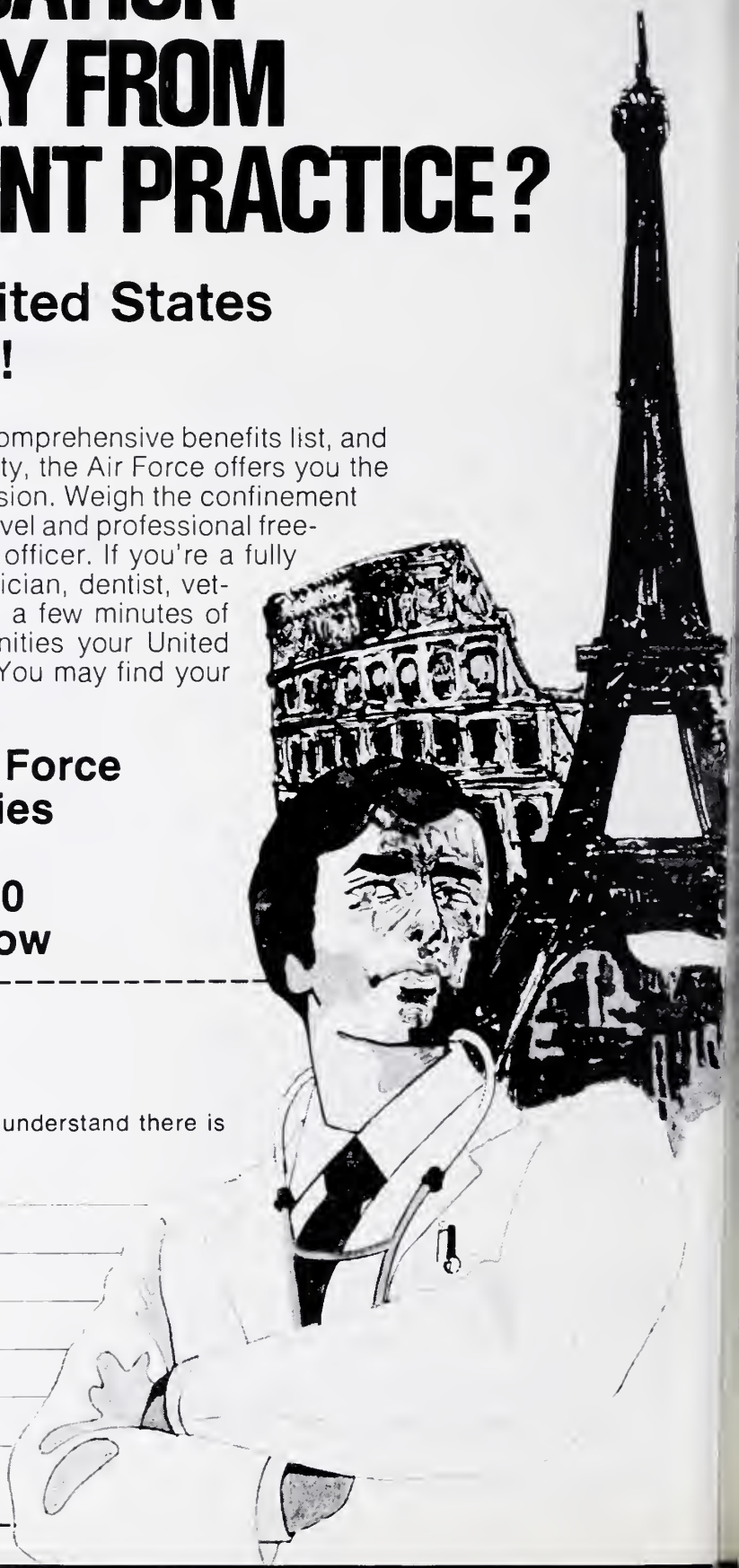

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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Planning for Cardiac Care by Colin W. Clipson and Joseph J. Wehrer. 407 pages. Illustrated. Price $20.00. Ann Arbor, Michigan, Health Administration Press, 1973.

Allergy, Brains, and Children Coping by Ray C. Wunderlich, M.D. 170 Pages. Illustrated. Price $7.00 (hardcover) $5.00 (papercover). St. Petersburg, Florida, Johnny Reads, Inc., 1973.

Symposium on Reconstruction of the Auricle by Radford C. Tanzer, M.D. and Milton T. Edgerton, M.D. 312 Pages. 611 Illustrations. Price $42.50. St. Louis, The C. V. Mosby Company, 1974

Heroin Addiction in Britain. What Americans Can Learn from the English Experience by Horace Freeland Judson. 200 Pages. Price $6.95. New York, Harcourt Brace Jovanovich Company, 1974.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D. 640 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1974.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Birth Defects, edited by Arno G. Motulsky and W. Lenz. 373 Pages. Illustrated. Amsterdam, Excerpta Medica, 1974.

Review of Medical Pharmacology, 4th Edition. by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 721 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974

Handbook of Obstetrics & Gynecology, Fifth Edition, by Ralph C. Benson, M.D. 770 Pages. Illustrated. Price $8.00. Los Altos, California, Lange Medical Publications, 1974.

Psychiatry in Primary Care by Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 Pages. Price $12.95. St. Louis, The C. V. Mosby Company, 1974.

Lifesaving, Rescue, and Water Safety by The American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Garden City, New York, Doubleday and Company, Inc., 1974.

In Defense of the Body by Roger Lewin. 146 Pages. Illustrated. Price $2.50. Garden City, New York, Anchor Press/Doubleday, 1974.

Referring the Psychiatric Patient by Larry R. Kimsey, M.D. and Jean L. Roberts, M.D. 80 Pages. Price $6.95. Springfield, Illinois, Charles C. Thomas, Publisher, 1973.

Clinical Perinatology edited by Silvio Aladiem, M.D. and Audrey K. Brown, M.D. 492 Pages. 135 Illustrations. Price $41.50. St. Louis, The C. V. Mosby Company, 1974.

The Malnourished Mind by Elie A. Shneour. 209 Pages. Illustrated. Price $2.95. New York, Anchor Press/Doubleday, 1975.

Current Medical Diagnosis and Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,044 Pages. Price $13.50. Los Altos, California, Lange Medical Publications, 1975.

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Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.

b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake. *"Destabilization" of Previously Controlled Diabetic:* When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

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Adverse Reactions: Principally gastrointestinal unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

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equipment wanted

WANTED: Otolaryngology equipment for establishment of new practice. Call George R. Farrell, M.D. (305) 523-2460.

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)isruptive anxiety usually meets its match here.

)ften effective when reassurance and counseling are insufficient. Three dosage strengths to meet most therapeutic needs.

fore prescribing, please consult complete uct information, a summary of which vs:

dications: Relief of anxiety and tension rring alone or accompanying various se states.

ntraindications: Patients with known rsensitivity to the drug.

rnings: Caution patients about possible ined effects with alcohol and other CNS ssants. As with all CNS-acting drugs, on patients against hazardous occupa- requiring complete mental alertness operating machinery, driving). Though cal and psychological dependence have y been reported on recommended doses, aution in administering to addiction- e individuals or those who might increase ge; withdrawal symptoms (including ulsions), following discontinuation of the and similar to those seen with barbitu- , have been reported. Use of any drug in nancy, lactation, or in women of child- ng age requires that its potential benefits eighed against its possible hazards.

ecautions:

AL: In the elderly and debilitated and in ren over six, limit to smallest effective ge (initially 10 mg or less per day) to ude ataxia or oversedation, increasing ually as needed and tolerated. Not recom- ded in children under six.

JECTABLE: Keep patients under observa- preferably in bed, up to three hours after injection; forbid ambulatory patients to ate vehicle following injection; do not nister to patients in shock or comatose s; use reduced dosage (usually 25 to 50 for the elderly or debilitated and for ren age twelve or older.

AL AND INJECTABLE: Though generally ecommended, if combination therapy other psychotropics seems indicated, ully consider individual pharmacologic ts, particularly in use of potentiating ounds such as MAO inhibitors and othiazines. Observe usual precautions in nce of impaired renal or hepatic func- Paradoxical reactions (e.g., excitement, ulation and acute rage) have been ted in psychiatric patients and hyper- le aggressive children. Employ usual

precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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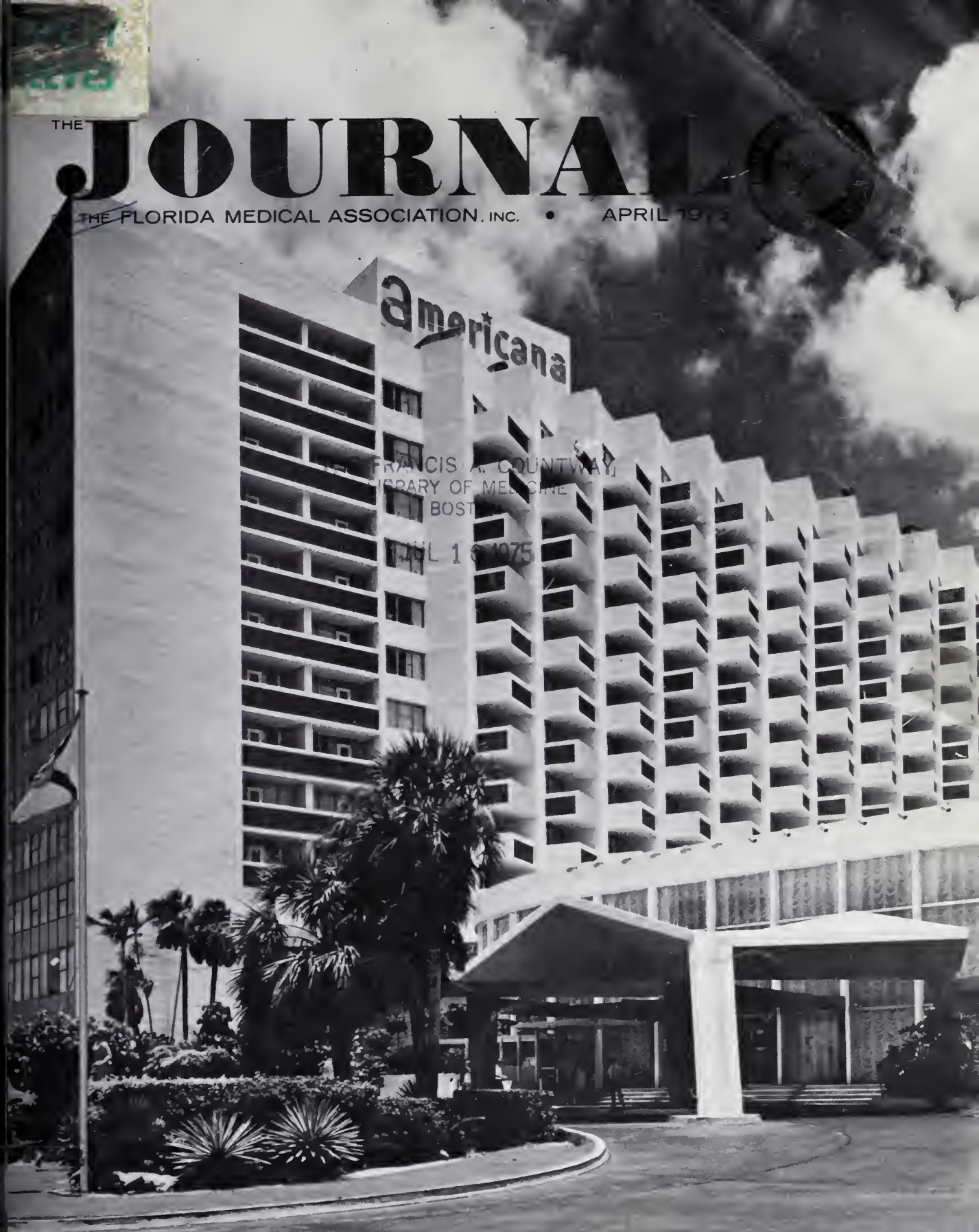

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APRIL, 1975 • VOLUME 62 • NUMBER 4

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April Cover—Americana Hotel, Bal Harbour, Miami Beach, site of the Florida Medical Association Annual Meeting, April 23-27, 1975

President's Page

Communication

The word, communication, has many definitions in Webster's dictionary — intercourse by words, letters or messages; interchange of thoughts or opinions by conference or other means—and most of them emphasize a key need of the officers and members of the Florida Medical Association as we work together. When we fail to understand each other's actions, we have only misunderstanding to the detriment of all.

At this time vital decisions are being made in critical areas by leaders of the Association and the county medical societies which not only affect us now but will profoundly influence our lives in the years to come. It is essential that all of us become aware of our problems and follow the efforts being made to solve them. We must work together toward a solution if we are to cause others to understand the many ramifications of our dilemma which affects the quality of care we provide our patients and the cost of this care.

The model physician within his community and among his peers is learned, concerned and enjoys his practice. He is proud to be a physician following his profession in the United States. He has empathy with his patients. He understands the problems of his colleagues and reserves judgment until the facts are known whether of philosophy, medicine or professional conduct. This is a picture of many Florida physicians.

We have the respect of our fellow physicians. We have the confidence of our community leaders. We have the trust of our patients. With this background and with common goals, we can move the mountains — if we communicate.

Linda and I appreciate the many courtesies members of the Florida Medical Association have shown us through my year as your President. It has been an experience for us; one we have thoroughly enjoyed.

Thad Moseley

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Those 49 Category I Continuing Medical Education courses are the largest number ever offered at an AMA convention. On top of that, there'll be Category I symposia and medical motion pictures on a wide variety of specialties.

Also featured are a number of special interest programs: a two-day session on the Medical Aspects of Sports, a series of special courses on clinical pathology, and a joint program by the American Veterinary Medical Association and the AMA on diseases transmitted to man by household pets. Physicians' wives and families will be offered interesting programs co-sponsored by the AMA's Council on Scientific Assembly and the Woman's Auxiliary of the AMA.

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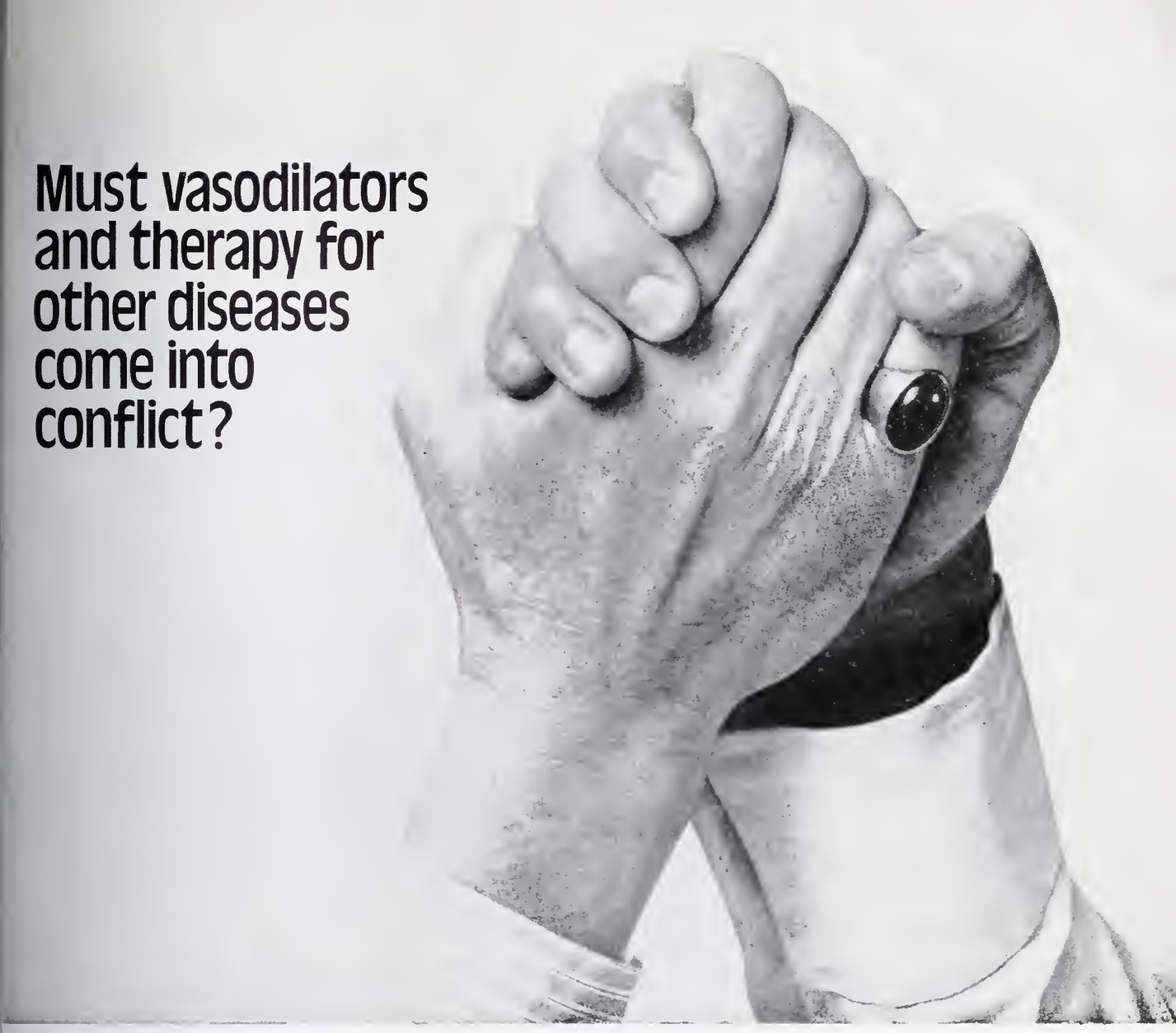
Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

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(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Deaths

Bailey, Walter Harold, Englewood; born 1905; Vanderbilt University, 1934; member AMA; died January 22, 1975.

Baumgartner, Carl J., Jacksonville; born 1883; College of Physicians and Surgeons, 1911; member AMA; died January 13, 1975.

Coe, John E., St. Petersburg; born 1924; Albany Medical School, 1948; member AMA; died October 7, 1974.

Davis, Harold E., Miami; born 1894; Northwestern U., 1926; member AMA; died October 12, 1974.

Dupuy, Samuel S., Coral Gables, born 1912; Medical College of Virginia, 1938; member AMA; died November 5, 1974.

Feinberg, Harry, Lauderdale Lakes; born 1908; New York Medical College, 1933; member AMA; died June 20, 1974.

Freeman, James V., Clearwater; born 1910; Harvard University, 1936; member AMA; died January 12, 1975.

Hutson, Thomas W. Sr., Miami; born 1889; Medical College of South Carolina, 1912; member AMA; died October 27, 1974.

Jimenez, Manual E., Miami; born 1907; Havana Medical School, 1941; member AMA; died June 27, 1974.

Kline, Lewis LeRoy, Orlando; born 1913; Loma Linda University, 1940; member AMA; died January 27, 1975.

Lippow, Charles, Miami Beach; born 1893; U. of Bern, Switzerland, 1917; member AMA; September 9, 1974.

Pickett, Wilbur C. Jr., Daytona Beach; born 1930; Maryland Medical School, 1956; member AMA; died October 7, 1974.

Rand, Harold, Miami; born 1908; Western Reserve, 1932; member AMA; died October 30, 1974.

Rudolph, Jack A., Miami; born 1904; Jefferson College, 1928; member AMA; died October 13, 1974.

Steinberg, Benjamin Louis, Miami Beach; born 1905; University of Iowa, 1931; member AMA; died January 24, 1975.

Stocking, Bruce W., Fort Lauderdale; born 1905; U. of Michigan, 1930; member AMA; died—date unknown.

Swink, Robert L., Miami; born 1923; Maryland Medical School, 1947; member AMA; died October 10, 1974.

Trombly, Frank Willis, Miami; born 1916; College of Physicians and Surgeons, 1943; member AMA; died January 27, 1975.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monifial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults — 600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children — 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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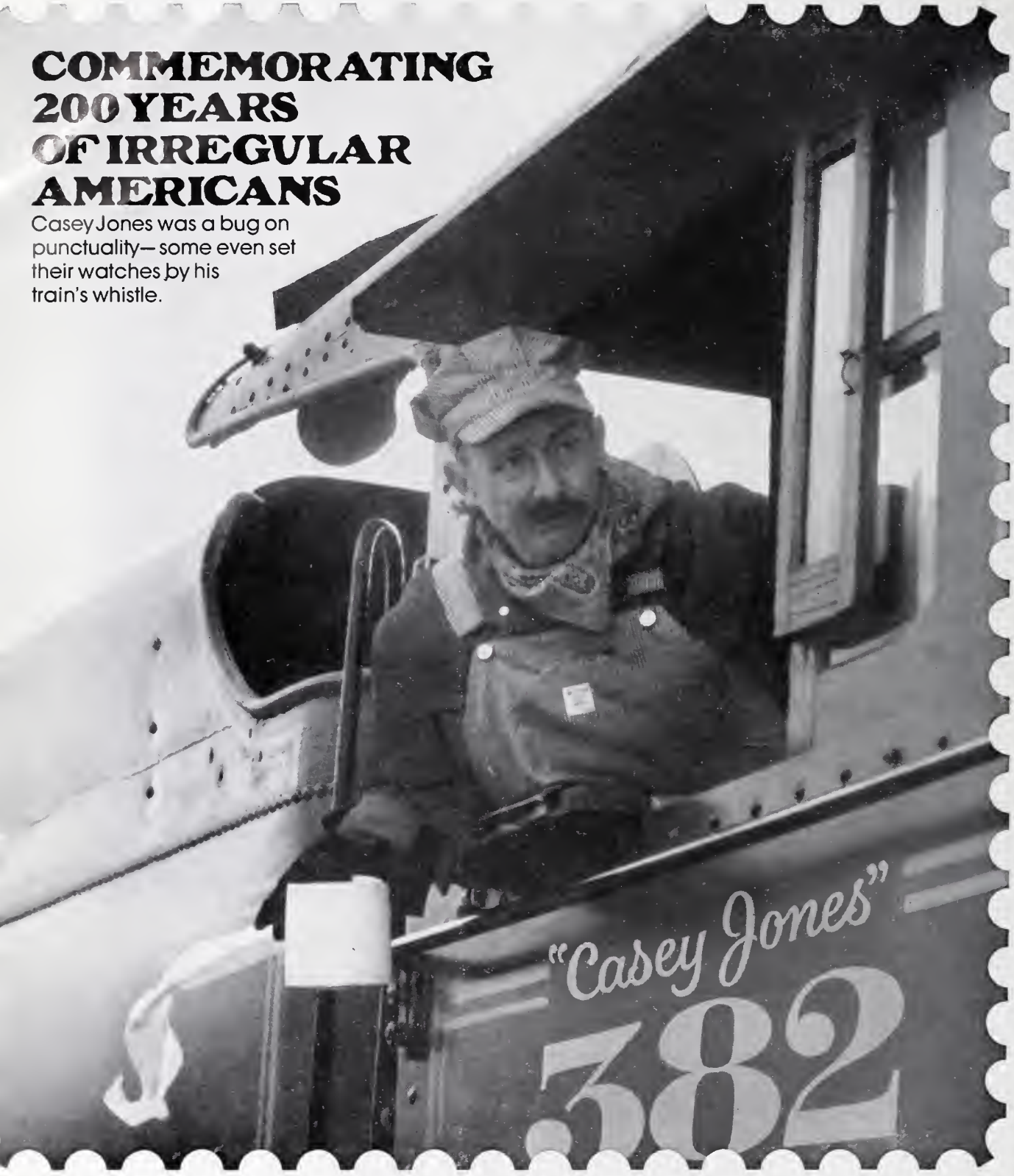

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1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

Every batch of Synthroid® T_4 is of controlled potency. (sodium levothyroxine, U.S.P.) FLINT

SYNTHROID is T_4. It provides your patients with everything they need for complete thyroid replacement therapy.

1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

Synthroid®

(sodium levothyroxine, U.S.P.) FLINT

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

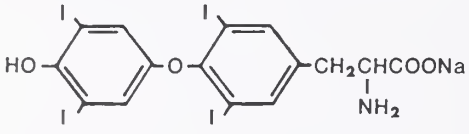
See reverse side for full prescribing information.

Synthroid®
(sodium levothyroxine, U.S.P.*) FLINT

Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets,** taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets,** the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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Deerfield, Illinois 60015

*U.S. Pat. 2,889,363

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

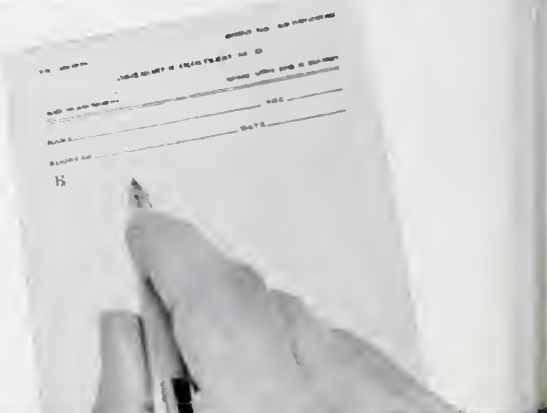
CONTRAINDICATIONS: Aminophylline Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

Bioequivalence



the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

Ortho announces
a unique,
broad-spectrum
anthelmintic
effective against
whipworm...
new
Vermox
TRADEMARK
chewable
tablets
(mebendazole)

© OPC 1975

...and highly effective against roundworm, hookworm and pinworm in single or mixed infections

No dosage calculations — one simplified dosage, regardless of weight or age†

whipworm, roundworm, hookworm and mixed infections:
1 chewable tablet b.i.d. for 3 consecutive days

pinworm: 1 chewable tablet

If the patient is not cured three weeks after treatment, a second course of treatment is advised.

highly effective

	Mean cure rates	Mean egg reduction
Whipworm	68%	93%
Roundworm	98%	99.7%
Hookworm	96%	99.9%
Pinworm	95%	— — —

simplicity of administration patients can take the tablet at any time. It can be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

not a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

convenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

well tolerated transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

†Vermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Indications Vermox* (mebendazole) is indicated for the treatment of *Trichuris trichiuro* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.

Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

Contraindications Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults.

For control of trichuriasis, ascariasis, and hookworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

*TRADEMARK

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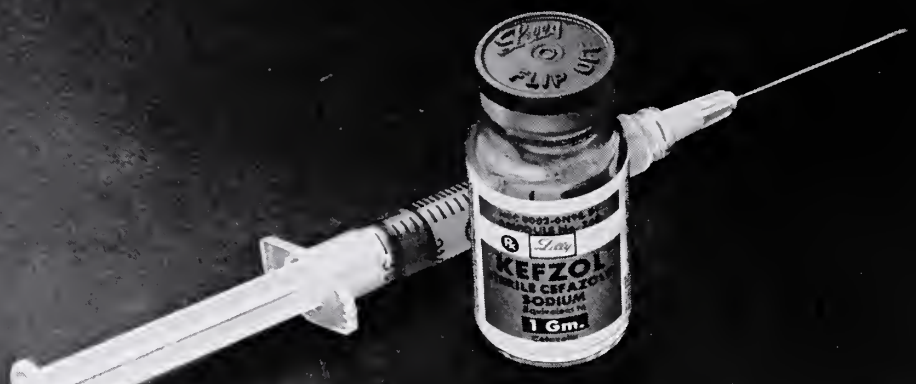
Ortho Pharmaceutical Corporation,
Raritan, New Jersey 08869

Kefzol®
cefazolin sodium

Ampoules, equivalent to 1 Gm. of cefazolin



Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

APRIL, 1975 • VOLUME 62 • NUMBER 4

A Regional Center for Team Treatment of Cardiovascular Disease

JAMES R. JUDE, M.D., IRWIN B. BORUCHOW, M.D., AND RAMANUJA IYENGAR, M.D.

Abstract: A regional referral center for team treatment of cardiovascular disease and especially coronary artery disease has been established. Highly skilled personnel and specialized equipment, including intraoperative coronary cinearteriograms, are available. Intraoperative coronary cinearteriograms have proven invaluable in allowing the performance of a thorough and excellent technical procedure. Occasionally we have been very surprised by the findings and have made serious alterations in the surgical approach because of the data obtained. Quality care is delivered to all patients and their physicians as an extension of their own hospital setting. The entire operation is directed toward not only efficient but also economic provision of health care.

The increased demand for diagnosis and therapy of coronary artery disease has outstripped existing facilities, generally at university hospitals. Therefore, new demands for the provision of health care have been placed on community hospitals. Indeed, many procedures can be performed more effectively and more economically in the private practice setting. Since the specialized equipment, personnel and technical facilities are extremely expensive, they must be utilized at optimal levels. A great duplication of facilities in any geographic area would be impractical. However, most referring physicians, especially cardiologists, wish to continue to be involved in the diagnostic protocol and decision-making process.

In order to meet the increasing demands and to offer a referring physician the ability to participate, we have organized our resources as a total team effort: initial personal physician-cardiologist - diagnostic facilities - cardiac surgical evaluation-cardiac surgery-continued home care-long term evaluation.

Materials and Methods

A cardiovascular unit was created within an established 325-bed community hospital to serve as a definitive diagnostic (including stress testing, cardiac catheterization) and medical/surgical therapy center for multiple area hospitals with over 2,000 cumulative beds. The hospital provides standard facilities for regular and vascular radiology, clinical and anatomical pathology (with a special interest in cardiovascular histology), respiratory therapy and renal dialysis. The cardiovascular unit comprises 6,000 square feet of new space (Fig. 1) and includes offices for the surgeons, anesthesiologists, and cardiologists, two fully equipped cardiac catheterization laboratories, a biochemical laboratory, a ten-bed surgical intensive and intermediate care unit, two cardiac surgery operating rooms, conference rooms, family waiting facilities and an extensive television communications network. One of the operating rooms is equipped with cineangiography equipment so that intraoperative coronary arteriography may be performed. The cardiovascular unit is immediately adjacent to one of the regu-

Dr. Jude is director and Dr. Boruchow assistant director of the St. Francis Hospital Cardiovascular Center, Miami Beach. Dr. Iyengar is director of the Center's Cardiac Catheterization Laboratory. Dr. Jude also is Clinical Professor of Surgery at the University of Miami School of Medicine, Miami.

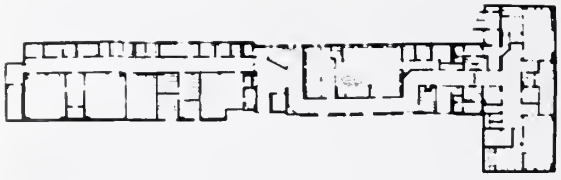

Figure 1a

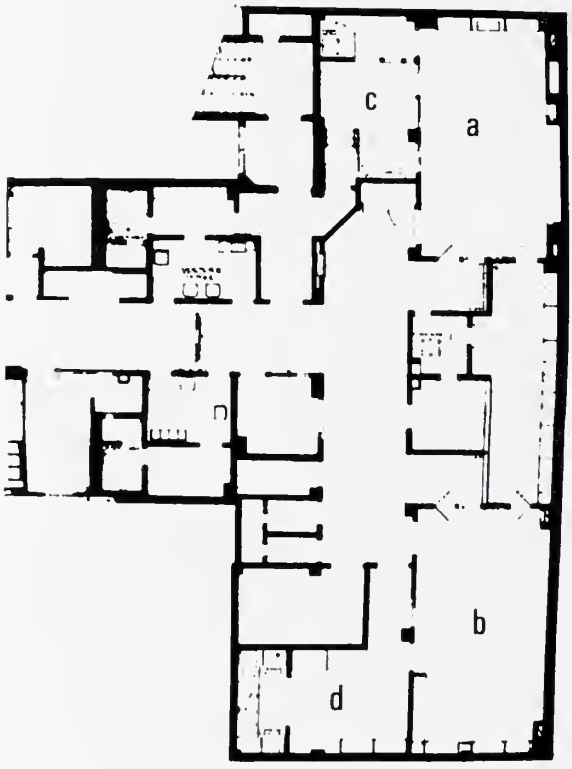

Figure 1b

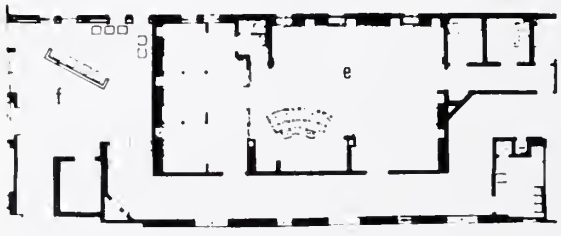

Figure 1c

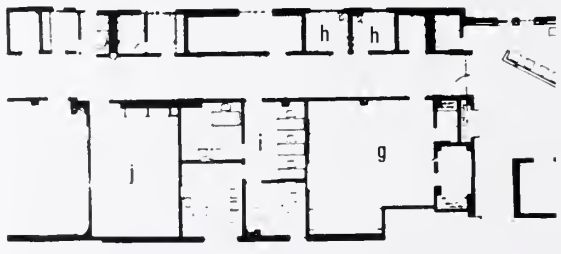

Figure 1d

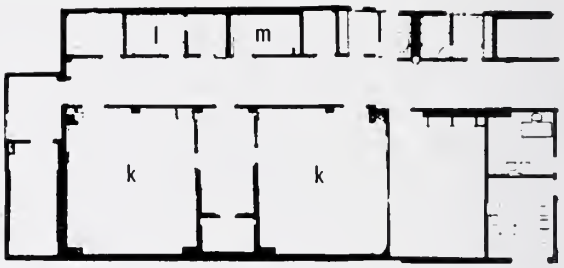

Figure 1e

Fig. 1.—1a—Floor plan of St. Francis Hospital Cardiovascular Center. 1b—Details of floor plan: (a) Operating Room #1, (b) Operating Room #2, (c) Gallery, (d) Pump Room, (e) Surgical Intensive Care Unit, (f) Lobby and Waiting Area, (g) Conference Room, (h) Examining Rooms, (j) Chemistry Laboratory, (k) Cardiac Catheterization Rooms, (l) Darkroom, (m) Art Room.

lar 48-bed hospital floors which specifically serves as a pre- and postoperative floor for cardiovascular patients with nurses trained in respect to the psychological as well as physical needs of these patients.

This facility was designed to serve a regional need. It was quite apparent that each hospital in the south Florida area could not have all of these facilities; yet physicians practicing in the area desire to participate in a substantial way in the current effort to combat heart disease. Inpatients from area hospitals are scheduled for diagnostic or therapeutic evaluation and returned to the referring institution (and the care of their own private physician) on the same or the following day. When indicated, immediate decisions for urgent surgery have been made with the personal physician. The flow, therefore, has been from the patient's personal physician (who performs the initial evaluation and makes the decision from a longitudinal knowledge of the patient as to the need for further diagnostic studies) to the medical cardiology section of the cardiovascular center. The patients are admitted to the immediately adjacent hospital floor and subjected to appropriate diagnostic maneuvers including lipid profile, vectorcardiography, stress testing and a full cardiac catheterization as indicated. Surgical consultation is immediately available when the results of these studies have been completed. The information is then voice communicated to the patient's referring physician and a joint decision reached as to the need for medical or surgical treatment. The patient is returned to the hospital room and may then be transferred

back to his own personal physician for continued medical care, or to the operating room, as the need dictates. Patients who undergo cardiac surgery are reevaluated by the cardiovascular center team, including the private physician, at specified intervals, including repeat stress testing and cardiac catheterization.

The staff of the regional cardiovascular center has participated regularly in the medical conferences of the area hospitals. By the employment of television tape cassettes, the various diagnostic and therapeutic procedures employed on patients referred from a particular hospital are presented. In this way, the referring physicians become active participants in the decision-making process.

Results

Utilizing this approach and the diagnostic facilities of the regional cardiovascular center there have resulted 100 open heart operations with an overall 5% mortality rate. A breakdown of these procedures includes: coronary artery bypass grafts (54 cases), valve replacement (24 cases), combined procedures (9 cases), and other procedures (13 cases). The average patient's stay has been ten hospital days if he undergoes surgery, at an approximate cost of $400 per day.

Intraoperative coronary angiography has yielded clinically valuable data. In one case intraoperative coronary arteriography showed a vein bypass graft placed proximal to an obstructive lesion (Fig. 2). It then was possible to go back on cardiopulmonary bypass and correct the error. In another situation, a vein bypass graft was performed to the left anterior descending coronary artery, whereas a far more severe lesion was present in a diagonal branch. This lesion was not evident on the initial cardiac catheterization but was readily apparent on the intraoperative cine coronary arteriogram (Fig. 3). The patient was then placed back on cardiopulmonary bypass and another vein graft performed to the diagonal branch (Fig. 4). From such studies new data will become available which will help in terms of case selection and ascertaining the reasons for early and late vein graft failure.

Discussion

Heart disease, and especially coronary artery disease, has obviously reached epidemic proportions in the United States. It is the leading cause of death in this country and frequently affects

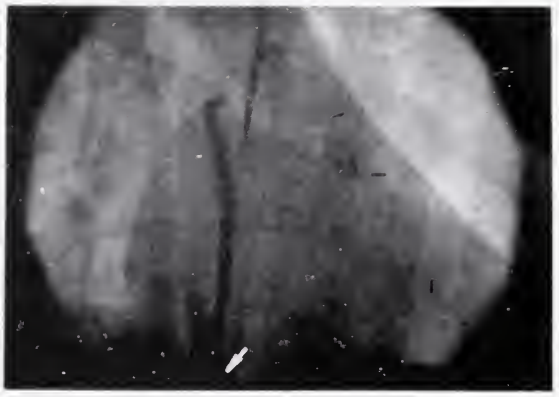

Fig. 2.—Intraoperative Coronary Cineangiogram. Right coronary artery bypass graft placed proximal to obstructive lesion. Cardiopulmonary bypass reinstituted and error corrected.

Fig. 3.—Intraoperative Coronary Cineangiogram. Vein bypass to left anterior descending coronary artery. Note unsuspected severe lesion in first diagonal. Cardiopulmonary bypass reinstituted.

Fig. 4.—Intraoperative Coronary Cinearteriogram. Same patient as Fig 3. Vein graft to first diagonal. Note severe proximal obstruction.

those in the wage-earning years. Loss of productivity has been enormous. With the advent of vein bypass surgery for coronary insufficiency, the demand for open heart facilities has mushroomed. Therefore, a need has been placed on the community hospital to perform a service in terms of delivery of health care for therapy of this national problem. Expensive and highly specialized, the need has been a burden not accepted readily by hospital administrators. Conflicts result with the medical staff who want such diagnostic and therapeutic capabilities for their patients and also have a personal desire to be a part of what has been considered academic quality care. Yet, the hospital administration is frequently not able to or even allowed to comply because of third party payment restrictions. With these thoughts in mind, the concept of a regional medical-surgical-cardiovascular center originated and subsequently was put into actual practice. It provides, by virtue of the large number of referring beds, a distribution of the cost factor. Thus, quality diagnostic and therapeutic care is provided expeditiously while involving the patient's personal physician at each level, including the long-term evaluation. This facility is unique in that it is a completely consolidated patient-oriented medical-surgical unit. There are interlocking feedback communications from the patient's personal physician to center cardiologists and surgeons and back again to the personal physician. Highly specialized and expensive capabilities have already yielded valuable results in terms of discharging the quality clinical care expected today. Routine intraoperative cinearteriograms provide an example of the value of these capabilities. They have been performed at the conclusion of all coronary artery bypass operations and have been particularly useful in studying the technical characteristics of the anastomoses as well as the distal coronary artery segment. If there is a technical problem with the anastomosis or if the anastomosis has been placed proximal to an obstructing lesion correction is carried out prior to chest closure. As a research tool, it is believed that it will be possible to correlate the angiographic findings on the operating table with flow measurements of the bypass grafts in terms of prognosticating graft patency. In our recent experience, poor angiographic runoff at the time of operation is the single most important factor accounting for graft failure. Certainly, further information along these lines is needed and we expect to obtain substantial data in this regard.

Summary

A regional referral center for team treatment of cardiovascular disease and especially coronary artery disease has been established. Highly skilled personnel and specialized equipment, including intraoperative coronary cinearteriograms, are available. Quality care is delivered to all patients and their physicians as an extension of their own hospital setting.

The entire operation is directed toward not only efficient but also economic provision of health care.

▶ Dr. Jude, 250 West 63rd Street, Miami Beach 33141.

It takes only one generation for a good thing to become a bad thing, for an inference to become dogma. Dogma is the enemy of truth and the enemy of persons. The ideas enshrined in dogma may include good and wise ideas, but dogma is bad in itself because it is accepted as good without examination.

O.K. Words from I'm Okay — You're Okay selected by Dan Drake and submitted to us by F. Norman Vickers, M.D., Pensacola.

The Orbiting Psychiatric Patient

Richard E. Gordon, M.D., Ph.D. and Susan Webb, M.S.W.

Abstract: This paper describes the peripatetic psychiatric patient who travels from state to state requiring hospitalization in different areas of the country. We have called him the orbiting psychiatric patient. As shown by the data, a resort state like Florida receives a disproportionate share of these patients. Their characteristics are described and several examples provided. Many orbiting patients have criminal charges against them. A possible program for managing the pensioned orbiting patient is described.

For the past two decades a wanderlust has hit the nation. Transients of all ages from high schoolers to golden agers travel about the country by every means. This national mobility contains seasonal travel to resort areas and permanent migration to the south and southwest. Attracted by Florida's climate both emotionally healthy and financially independent transients, vacationers, and retirees, and also less stable ones—drifters, criminals, delinquents and emotionally ill persons—move into and out of the state.

The administration of the adult public assistance programs—Aid to the Aged, Blind and Disabled—has recently been taken over by the Social Security Administration. This means that it will be easier than ever before for emotionally ill persons to move into Florida and other resort states because there is no longer a threat of a temporary loss of funds. The emotionally disabled require special consideration since ill persons and their families, especially those accustomed to receiving assistance, are very likely to have greater health care needs than the emotionally well population and to require other types of social services, such as public assistance, and vocational rehabilitation. These services, of course, require additional financial support, especially if they cause a cycle of dependency which is repeated from generation to generation. As increasing numbers of emotionally disabled migrants enter a community they very commonly overtax the area's social services and other facilities.

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Presented before the Section on Psychiatry, Florida Medical Association, 100th Annual Meeting, May 9, 1974, Hollywood-by-the-Sea.

Florida's legislators have considered passing a law to charge new residents for the increased expense to government caused by their moving into the state. They are looking at the costs of material resources: water supply, power-generation, sewage and garbage facilities, and of services: schools, police, and fire protection. They have not attempted to foresee and tax in advance the special expenses that will be generated by emotionally disabled migrants: medical, psychiatric, correctional and other social and welfare needs.

This paper will provide preliminary information on the interstate migration of psychiatric patients to Florida. It will pay particular attention to the demographic and other characteristics of mentally ill transients.

Method

Data about out-of-state patients in the state hospitals were collected from the Divisions of Mental Health and similar agencies in Florida, New York, New Jersey, California, etc.

Data about demographic characteristics of migrating psychiatric patients were obtained from the records of inpatients on psychiatric services in Gainesville, Florida. Information was gathered as to birthplace, length of residence in the State of Florida, age, work habits, number of hospitalizations, marital status and service connection for disability. The inpatient and outpatient units of the Shands Teaching Hospital of the University of Florida and the District V Community Mental Health Clinic have provided examples of typical patients.

Results

Of the 5,762 admissions to state mental hospitals in Florida during the year July 1972 to June 1973, 7.0% (399) were from out-of-state. Among these 60% were men and 40% women. Only 16.8% (67) of them were actually transferred, the remainder continuing to receive care in Florida.

In contrast, California reported in 1972 that 0.3% (89) of all 25,810 admissions to state hospitals were from out-of-state; other out-of-state figures were: for Indiana, 2.0% of 3,742 total

admissions; for South Dakota, 0.7% of 1,917 admissions; for New Jersey, 3.0% (389) of 12,716 admissions; for New York (1973), 1.0% (340) of 32,658 admissions, for Massachusetts (1973), 0.3% (28) of 9,177 admissions; for North Dakota (1973), 1.8% (35) of 1,989 admissions; for Colorado (1973), 0.2% of 1,795 admissions.

Only 63 requests for transfer to Florida were made for patients hospitalized in other parts of the country. More than half (32) were transferred to Florida, yet only 16 of the 63, less than 25% were actually Florida residents. This means that Florida was far more likely than its fellow states to end up taking care of a mentally ill out-of-state patient.

Seventy-six of the nonresident patients who drifted into Florida no longer gave a state of residence. They had wandered about the nation much of their lives, never staying long enough in one location to establish an official residence.

The Mentally Disordered Offender

Fully 15.7% of the 225 men and 28 women at South Florida State Hospital against whom there are criminal charges were nonresidents of the state! Note that 89% of these 253 patients were men. Patients were charged with criminal offenses ranging from vagrancy to first degree murder. Unless the charges can be dropped they are not returned to their home states but continue to receive care in Florida. Compare these figures to those of inmates in the custody of the Division of Corrections in Florida. Among 10,346 prisoners in state prisons in June 1973, 23% had been in the state for less than six months.

Other aspects of this problem of the out-of-state mentally ill patient are seen by looking at demographic statistics. Forty-four per cent of 96 psychiatric patients who were admitted to the Gainesville VA Hospital in the spring of 1972 had migrated to the state within the previous ten years; in contrast the immigration rate for the state as a whole during the same ten year period was 19.5%. Thirty per cent of these patients had lived in the state less than three years and 15% less than one year.

Among the 53 immigrant patients 77% had previously been hospitalized; 64% were unattached—single, separated, divorced, or widowed; and 60% were unemployed. Furthermore, 49% of 53 migrating veteran patients but only 9.0% of 33 native Floridians were receiving a regular monthly disability pension, often supplemented by checks from the Social Security Administration and other sources. Their tax free income ranged from about $100 a month to, in most cases, $450 a month and, in a few, over $900 a month.

Discussion

The two striking features of this study are the great number of out-of-state admissions to psychiatric hospitals in Florida, and the large number of transient patients who have criminal charges against them. The data show that over three-fourths of these out-of-state patients have been hospitalized in other states; it is this group of transients who touch down in public and private hospitals in other states as well as Florida to whom we have given the label "orbiters." Their care is a problem crying for solution. Certainly the Community Mental Health movement is not reaching these persons in need of treatment who never settle permanently in any one clinic's catchment area.

Unlike most psychiatric patients, who characteristically are unaggressive and unlikely to become criminals, transient patients are often in conflict with the law; they become involved with the police, legal profession, courts, and correctional institutions. They provide a disproportionately high share of the residents of Florida's prisons and hospitals for the criminally insane. Often impulsive and violent, and without family and community ties to cause them to think twice about the consequences of their actions, they represent a continuing menace to the population both inside and outside institutional walls.

This outline summarizes our observations about orbiting patients.

Characteristics of the Psychiatric Patient in Interstate Orbit

1. He is usually male and unattached; if married he is having serious marital and family trouble.
2. Habitually, he does not cope with problems but avoids and escapes from them by entering hospitals, getting divorced, quitting jobs, leaving the state, etc.
3. His behavior is made possible by his having no permanent job to tie him down. In many cases he has an independent income, perhaps from disability insurance, the VA, social security, or a pension, often related to his illness, or from a private source such as a parent, inheritance, or investments.
4. He has been hospitalized previously in other states for his psychiatric disorder, recovering quickly from each episode of illness but, despite his symptomatic similarity to patients who do benefit, he does not improve with follow-up care.
5. He is very likely to get into trouble with the law, his crimes running the entire gambit of offenses from minor ones like vagrancy, through dealing in drugs and felonious assault, to rape and first degree murder.

Problems in Treating Interstate Orbiting Patients

Interstate orbiters do not remain in the community for long-term, outpatient care and they often gain from continuing in the sick role. Since, in effect his symptoms are being reinforced, the insecure, emotionally ill person, who avoids punishment for his antisocial activities by entering a hospital to be hospitalized each winter in a warm, rural atmosphere far from the icy north or receives a pension and compensation for disability, usually develops chronic emotional distress with repeated periods of decompensation.

Economic security and travel with the seasons are not enough to provide happiness and the good life; people need other kinds of positive reinforcement—respect, affection, appreciation, personal fulfillment and stimulating experiences in the social network in which they live. These supports are provided by family and home, neighbors and community, colleagues and work—the very providers which the patient has rejected.

The emotionally disabled orbiting person's working is discouraged, furthermore, by the treatment of insurance companies. Since he presents a high risk for accidents and further illness at work, insurors are reluctant to provide him and his employer with on-the-job coverage, even with a waiver. So disabled persons frequently cannot obtain permanent employment because employers are not allowed to hire them without workmen's compensation insurance.

Many of the nation's pension systems, whether for the elderly, disabled or indigent, reduce or eliminate benefits once the recipient begins to be gainfully employed. Thus, in addition to having his emotional and psychophysiological abnormalities automatically reinforced, the orbiting patient with a disability pension finds himself effectively punished for becoming well and attempting to achieve self-sufficiency.

The adversary legal system compensates litigant patients who continue disabled until their claims are settled; the VA disability review system, which requires periodic evaluation of a patient's illness to continue a disability pension, rewards patients who remain chronically ill and periodically turn themselves into the hospital.

In many public, private, state and VA hospitals, the size of next year's budget and the number of physicians, nurses, administrators, and other staff employed depend on the percentage occupancy of the hospital beds. These practices automatically tend to reinforce illness and inpatient care, otherwise wards would be closed and staff discharged. The medical staff, too, provide some of the motive force that helps send patients into orbit and keep them there. Because the patient does not permanently respond to care and keeps returning to the hospital reporting the same symptoms, and because he may be a troublemaker, he frustrates the medical staff; the latter respond eventually by tacitly evicting him, encouraging him to take his problems elsewhere. So Wisconsin's doctors recommend that their patients try the warm climate in Florida, and Florida's attempt to send them back to Texas, and the latter's urge them to live with relatives in New Jersey, and so on. The police and corrections officials, in the case of the mentally ill offender, behave likewise. The patient and the State of Florida end up as losers in this game. In summary, whole systems of service personnel with their facilities and institutions and the disabled persons themselves mutually reinforce each other in sustaining sickness. It is not surprising to find that, under this complicated system it is difficult to rehabilitate the emotionally disturbed patient who escapes punishment by being sick, or receives a pension, insurance award or disability payments that are reduced if he improves. There are usually too many effective forces blocking his recovery and rewarding his sickness for therapy to help him recover permanently.

Since Florida ends up taking care of many of these out-of-state patients it seems reasonable for the state to pioneer methods of doing the job effectively, and to be properly compensated for doing so.

Examples of Interstate Orbiters

Paul D., a 22-year-old white single man, was brought to us by police who found him on a highway near a swamp outside the city muttering about snakes and alligators. A midwesterner, he had hitchhiked to Florida three months earlier after an argument with his stern stepfather and worrisome mother. Prior to that he had made a three-year tour through Denver, San Francisco, Houston, New Orleans, and Atlanta, supporting himself by occasionally taking a job mixing milkshakes. Unable to settle down on returning home to Cleveland, he headed south with just a few dollars in his pockets. He reached Florida and obtained work doing odd jobs in a motel. There, learning from the other employees about the swamp and its dangerous quicksands and wildlife, he decided to test his courage by attempting to cross it barefoot at night, guided only by the stars. The following morning he emerged, unharmed but acutely psychotic, was picked up by a police car, and brought to us by way of the Community Mental Health Clinic to the inpatient unit for care. There we learned he had previously received brief psychiatric care both in California and in Texas during the previous three years.

Since the 1950s many American youths have been roaming restlessly around the country. Supported by allowances from home or by taking casual unskilled jobs, they have wandered in and out of the hippy sections of the cities, college towns, and communes. Among these young people are many emotionally maladjusted young women and men like Paul, whose travels also take them in and out of psychiatric hospitals in the states they visit.

Alvin S., a 50-year-old divorced real estate executive, was admitted to the hosptial complaining of constant anxiety and pains in the chest. These symptoms had plagued him for 30 years, ever since he began working part-time in his father's real estate business, managing apartments his father owned in Pittsburgh. His father, now in his 70s, still controlled the business he alone had built, and employed both his son, the patient, and his daughter, the patient's unmarried sister. Mr. S, whose mother had died when he was a child, had been hospitalized for his disorder a dozen times, all at his father's expense. At first he was treated on medical services but eventually he became a psychiatric patient, although he and his father remained unconvinced that his complaints were not physical.

The patient's father was a highly emotional person who kept a tight hold on all aspects of his business and his son's life. He often shouted criticisms at his son, never trusted him to act independently, and blamed and criticized his son's wife and the way she raised her children.

Mr. S's father supported him well financially whether he worked or not and frequently sent the patient to Florida to rest and to hospitals whenever the patient became particularly anxious. During the early years of his son's care, the father participated in a few stormy family therapy sessions in which the double-bind in which he kept the patient was discussed. After that, the patient's father would have nothing more to do with his treatment other than to pay the bills and criticize psychiatry. The patient's marriage broke up when he broke his wife's jaw after accusing her of unfaithfulness; the children remained with their mother.

Mr. S continued to depend on his father, occasionally going to the family business office. He shuttled back and forth between Pittsburgh and Florida, spending a month or two every several years in a psychiatric hospital, his recurrences being precipitated usually by an argument with his father, sister, divorced wife, or children.

This patient provides an example of how families support a patient's avoidance behavior rather than help him to settle down and find solutions to his problems.

"I was never allowed to work," James S., a 75-year-old World War I veteran patient told us when asked about his employment. "I've got a disability pension from when my nerves gave out and I'd have lost it if I got a job."

The patient had been sent to us by his young wife's lawyer who was concerned about her acquiring her husband's power of attorney. The patient had become senile, disoriented for time and place, and forgetful of recent events, although he remembered that he had several "Alabama kids" and "Georgia kids" still living with his former wives in the homes he had once shared with them. Mr. S distrusted his "Florida bride" and was balking about signing his pension checks over to her. They totalled nearly $1,000 per month from the VA and Social Security. Without his signature she had insufficient funds to manage their home and 50 acre farm and to care for their three preschool children.

Since developing an anxiety neurosis at the age of 17, just prior to embarking for France 57 years previously, this patient has received, we estimate, the taxfree equivalent of over $300,000 in today's money.

Despite what he initially told us about his work experience, the patient had held jobs long enough after the Old Age and Survivors' Assistance (Social Security) laws were passed to become eligible for full payments, but never for enough pay as to lose his pension. He lived frugally but comfortably and invested his surplus money in land and houses in three states. His wife's attorney was worried about her ability to manage an estate worth well over $100,000, and asked us to examine the patient and determine whether he was incompetent and needed a court-appointed guardian.

Mr. S had moved whenever he became distrustful about his wife of the moment. Moving on to a new state, always within easy reach of a veteran's hospital where he could obtain psychiatric hospitalization, he would obtain a divorce and soon remarry. He has finally come down out of orbit in Florida and will probably spend his declining years in a state mental hospital here.

A Plan for Helping the Pensioned Orbiting Patient

Community psychiatry cannot permanently help the patient who does not remain in a community. A patient may, of course, reject help or accept it, the option is his. Nevertheless, to recover permanently a patient needs his own turf, and must be encouraged to settle down, plant roots, and become involved in continuing psychiatric therapy. Then he can begin to develop the self control and interpersonal, social, vocational and recreational skills that will help his rehabilitation. Psychiatrists and other mental health personnel can then work with him to resolve his problems. To encourage this process, we recommend continuing pensions for the emotionally disabled but replacing the present pension system with a new approach—a graded schedule of payments made contingent upon improvements in the orbiting patient's behavior. Our recommendations, therefore, are as follows:

1. A disabled, pensioned, orbiting patient should receive part of his payments in a residential allowance—to provide an incentive for his settling down in a community; it should begin after he takes up permanent residence in a community and should be cut off if he leaves the state.
2. Therapeutic communities should be established—halfway houses and sheltered villages are needed in towns within easy reach of mental health centers and their receiving and state hospitals. There, disabled psychiatric patients can remain out of the hospital and still receive mental health services.
3. Allowances should be greater for married pensioners living with their families than for single, separated or divorced patients.

To emphasize clearly to patients the benefits of learning and to induce them to work gainfully:

4. Disabled psychiatric pensioned patients should receive more pay and compensation for progressing in job and recreational training, as well as vocational training than for being idle, moving about the country, or entering a hospital. We recommend that recreational

training, as well as vocational training be supported, so that patients will develop play skills in order to avoid recurrence of depression and other symptoms.

5. Gainful employment should result in still greater income to the patient. He should be taxed on his earnings so that he can ultimately contribute more than he derives from his pension.
6. Suitable workmen's compensation insurance should be provided, perhaps guaranteed by the federal government, so that employers who hire emotionally disabled employees can conform with state laws.
7. Sheltered workshops should be developed in conjunction with each community mental health center. There, disabled migratory pensioned patients can undergo graduated training and rehabilitation at work, being compensated appropriately according to the minimum wage laws.
8. Funds should be provided to regional mental health delivery systems for caring for the patients in their districts, maintaining their health both as inpatients and outpatients. The amount supplied should be on a capitation basis rather than on the basis of percentage of occupancy of inpatient beds. The medical facilities should be accountable for their performance.
9. The patient's supplemental allowances should be administered with his medical care so that he clearly recognizes that his rewards are contingent upon his making progress and fulfilling each phase of his rehabilitative process. For example, a patient should not receive an allowance just by officially becoming a resident in a state but continuing in orbit, touching base only to collect his check.
10. Those patients with criminal charges against them should not be permitted to use their psychiatric illnesses to avoid sanctions, and control and remodeling of their behavior. Whether treated in hospital or prison, or as outpatients, they should remain under the custody or surveillance of professional corrections and probation officers who guide and monitor their conduct. Psychiatrists and other psychotherapists can then function therapeutically rather than punitively. Patients may, of course, choose whether or not to use the medical and psychotherapy offered, but this option is clearly separated from correctional control.
11. Last, but not least, Florida and other receiving states should receive additional federal funds to care for mentally ill out-of-state patients who come down out of orbit within their borders.

Acknowledgment

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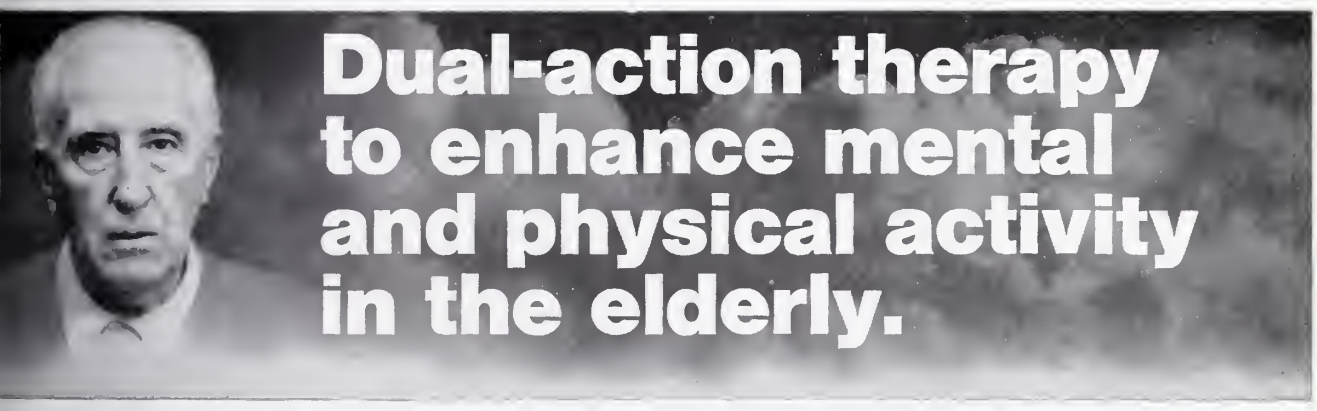

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Histiocytosis X

James C. Lanier, M.D.

Abstract: This report presents a patient who experienced all three clinical types of histiocytosis X within the first decade of life. The disease began at 14 months of age with an eosinophilic granuloma of the left tibia. At three years the Letterer-Siwe syndrome developed and at five diabetes insipidus completed the clinical picture of Hand-Schuller-Christian syndrome. The illness extended over 11 years; then no new lesions were found. He was treated with several different agents and underwent facial reconstructive surgery. He survived the disease and is now 24 years old. As residua there are micrognathia, exophthalmos, hearing loss and short stature.

Reports of Histiocytosis X have ranged from discussions of individual cases to extensive reviews with explanations of pathology, clinical course, and treatment.[1-5] This report is unique in that it concerns a patient whose first lesion appeared at age 14 months and at ten years of age had experienced the three clinical types of the disease.

Report of Case

The boy, born January 5, 1949 of a gravida 3 mother, had weighed 3.4 kg. The pregnancy had been full-term and the delivery without complications. He was breast fed the first year and appeared to be developing in a normal manner. He began walking at one year of age but a slight limp was noted. Two months later an orthopedist detected a swelling of the lower left tibia but no other abnormalities. Roentgenograms of the chest and long bones showed the chest to be clear but evidence of a destructive lesion in the lower left tibia. A cystic tumor was removed at surgery and the pathologist reported "granulomatous reaction including huge numbers of eosinophils and plasma cells, areas of focal necrosis as well as areas of fibrosis." Impression: "eosinophilic granuloma." Treatment consisted of curettage and closure.

The child became our patient in July 1951 at age two years five months. His weight was 8.6 kg and height 82.5 cm. Palpation revealed numerous depressed areas in the skull and the scalp was covered with a scaling crust. The four molar teeth were loose and the gums hypertrophic. The cervical lymph nodes were enlarged. Roentgenograms disclosed destructive areas of the mandible, parietal bones, mastoids, base of the skull, sella turcica, several ribs, left and right ilium and left tibia at the site of the original lesion.

The diagnosis was reticuloendotheliosis. He was admitted to the hospital and radiation therapy was begun through several portals. The lesions closed nicely; however, a foul discharge involving both ears became apparent.

In December a papular erythematous rash developed over the lower abdomen and around the neck typical of that in Letterer-Siwe type histioreticuloendotheliosis.

In March 1952 there was significant swelling of the cervical lymph nodes and the liver and spleen were found to be enlarged. He was readmitted to the hospital and nitrogen mustard 1 mg/kg daily was administered intravenously for four days. He also received blood transfusions and was discharged after three weeks. During hospitalization in April another course of nitrogen mustard in the same dose was given.

Aureomycin 50 mg twice daily by mouth was begun in May. The rash faded, lymph nodes became smaller, and the liver and spleen decreased in size. Exophthalmos developed and more areas of bone destruction appeared in the cranium, maxilla and mandible. All of the loose teeth were extracted. The foul external otitis remained and the ear canals became stenotic. Radiation therapy was continued. Bone destruction in areas of the pelvis was noted in November. More radiation was administered.

He was readmitted to the hospital in May 1953 where he received blood transfusions and a third course of nitrogen mustard similar to the two previous courses. Cortisone 25 mg four times daily was begun and the aureomycin was continued.

The cortisone dosage was reduced but not discontinued until October. The exophthalmos became worse. For four weeks in November he was treated with triethylene melamine (TEM) 0.04 mg/kg daily by mouth. At that time he weighed 11.45 kg, was 86 cm tall, appeared to feel well, played outdoors and could ride a tricycle.

Classical diabetes insipidus was diagnosed in March 1954 when he was five years three months of age and the clinical picture of the Hand-Schuller-Christian syndrome was complete. The urine had a specific gravity of 1.001. Roentgenograms again showed large cranial defects and multiple small ones. TEM 0.5 mg daily for ten days was administered and radiation to the pituitary area. The diabetes improved and did not recur; however, the exophthalmos persisted.

On July 5, 1955 the head circumference was 53.3 cm, chest 53 cm, height 95 cm and weight 13.8 kg. He entered public school in September; the aureomycin was discontinued. A few small new lesions continued to appear in the bone but no further treatment was given.

After 1961 no new bone lesions were detected. There was complete destruction of the mandible and no regeneration. He was referred to the Florida Crippled Childrens Commission in 1962 at age 13 years where reconstructive work on the mandible was begun. Bunch has reported on this procedure.[6]

On his last visit to our office in August 1966 at 17 years eight months of age he weighed 40.8 kg and was 137 cm tall. His general appearance was that of a short obese mature male. The skin was clear except for scars where bone had been removed for mandibuloplasty. The lymph nodes were not enlarged. The skull contour was slightly irregular, the scalp had full hair growth with no areas of alopecia. There was marked exophthalmos, otherwise the eyes were normal with 20/20 vision. The right external auditory canal was stenotic, the left atretic; hearing was impaired. There was marked micrognathia and he wore dental appliances. His voice was high pitched and the speech was somewhat indistinct. The heart and lungs appeared normal. The abdomen was soft; there were no masses or palpable viscera. Adult genitalia were present. He had a slightly waddling gait with some limitation of hip mobility.

Follow-up revealed that he completed high school at age 18½ years and then attended a technical school for two years. He recently reported that although he was able to water ski, fish and hunt, he was not gainfully employed.

Summary

This report records the expression of three clinical types of histiocytosis X in the same patient. It began with eosinophilic granuloma of the left tibia. Two years later manifestation of the Letterer-Siwe type emerged with typical rash and involvement of lymph nodes, viscera and bones. Still later exophthalmos and diabetes insipidus of the Hand-Schuller-Christian type developed. Vigorous treatment with radiation, cortisone, aureomycin, nitrogen mustard and triethylene melamine resulted in survival; however, bony defects of the mandible, absence of teeth and a short stature have produced a handicap. In spite of it this patient appears to be enjoying life at 24 years of age.

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Dr. Lanier, 2606 Park Street, Jacksonville 32204.

COMMENT by Thomas D. Miale, M.D.: The strength of this case report is the unusually long and detailed follow-up period; however, the absence of physical, laboratory and roentgenologic findings for the current eight year interval (1966-1974) is regrettable. In addition, the report does not appear to be oriented to the modern day histology of this disorder. Recent work, for example, has emphasized the need for subclassification of histiocytosis-x patients in order to estimate prognosis in a meaningful fashion (Newton, W. A., Jr., and Hamovoi, A. B.: "Perspectives," *Pediatric Pathology* 1:251, 1974). Another addition would be some investigation of the long-term effects of alkylating agents and radiation upon the hematopoietic system, and especially upon male fertility. This report then could be a potential source of information on this important but relatively unstudied area.

This report merits publication in order to refamiliarize Florida physicians with this uncommon condition. This entity often masquerades in many clinical disguises, and it presents significant diagnostic difficulties.

COMMENT by A. Ashley Weech, M.D.: This case report does have features of interest in tying together the three types of histioreticuloendotheliosis. The combination has been observed before and I think the paper would be of interest to a state journal.

The Most Powerful Motive

The sense of somebody's need is, I believe, the most powerful motive in the world, one that appeals to the largest number of people of every age, race and kind. It wakes up the whole nature, the powers that learn as well as those that perform; it generates the vigor of interest that submerges selfishness and cowardice; it arouses the inventiveness and ingenuity that slumber so soundly in students' classrooms. For many of us . . . work that is service taps a great reservoir of power, sets free some of our caged and leashed energy.

Richard C. Cabot

Torsion of the Fallopian Tube

Paul W. Oberdorfer, M.D.

Abstract: Torsion of the fallopian tube is an uncommon finding. The present case is presented because of its possible association with hysterosalpingography with an oil base medium.

Torsion of the fallopian tube is a recognized entity rarely encountered. Only once in 17 years has a case been recorded in a large general hospital where 10,000 to 15,000 surgical specimens are examined each year.

J. B. Sutton published the first description of torsion of the fallopian tube in 1890[1] and since that time scattered case reports have appeared in the literature, as well as several review articles and a large series.[2-5] Hansen reported ten cases from Denmark in 1970 and estimated an incidence of one case per 1.5 million women per year in the ten years 1957 to 1967.[6] He quoted Regad who reported 201 cases of which 20% were prepubertal girls and 80% patients 13 to 49 years old.[7] Twelve percent occurred in pregnant patients.

Blair reporting four cases in 1961 estimated that more than 300 cases had been recorded.[8] He noted six theories of causation.

Anatomic. Malformed mesosalpinx or abnormally long tube, hydatids of Morgagni or persistence of spiral winding of the tube from fetal life.

Physiologic. Disturbance of peristalsis.

Hemodynamic. Since the veins of the mesosalpinx are longer than the arteries, stasis in them may favor twisting of the tube due to the vessels' spiral course.

Sellheim theory. A sudden change in body position or acceleration or deceleration may produce abnormal motion of the internal genitalia.

Trauma. Accidents or other trauma.

Predisposing factors. Previous surgery or pelvic disease.

Since the patient's complaints center in the right side, most reports of isolated torsion mention frequent diagnostic confusion with appendicitis.[9]

For many years hysterosalpingography has been a widely used diagnostic procedure. In 1967 Siegler published an extensive review in which he stated that granuloma formation is an infrequent complication and occurs rarely in the normal tube because of active peristalsis.[10] No reference was made to torsion as a sequel to the procedure.

The following report is presented because of the rarity of torsion of the fallopian tube and the possibility of its relationship to a hysterosalpingogram made with an oily contrast medium.

Report of Case

The patient, a 32-year-old nulligravida x-ray technician, had a 12-year history of involuntary infertility. She was seen in the emergency room at 5:30 p.m. on January 3, 1973 with the complaint of severe cramping pain in the left lower quadrant of several hours duration followed by persistent vomiting. Her last menses had been on December 1, 1972 and she had noted a dark brown vaginal discharge on December 29.

The general history revealed good health with no prior abdominal surgery, drug allergy or drug use. Some eight years earlier a hysterosalpingogram reportedly had shown a longer than usual left tube with ampullary dila-

Fig. 1.—Surgical specimen.

Fig. 2.—Cut section of the surgical specimen.

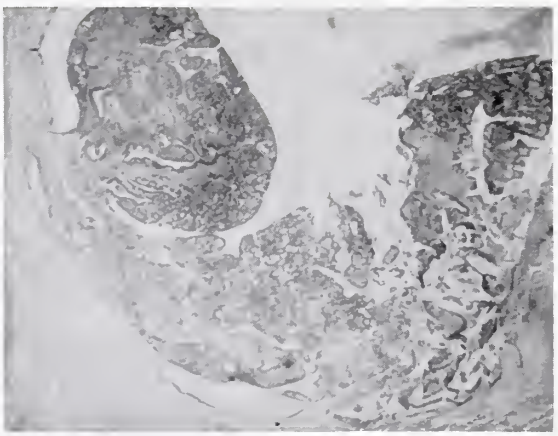

Fig. 3.—Microscopic view of the surgical specimen.

tion and spill into the peritoneal cavity. The procedure had been performed with an oil base medium.

According to the gynecologic history menarche had begun at age 12 or 13 and menses had been regular with a 28-day cycle and four or five days flow. She had mild dysmenorrhea, no intermenstrual or postcoital bleeding or dyspareunia.

There had been no tuberculosis, cancer, diabetes or blood dyscrasia in her family.

Physical examination revealed a well-developed, well-nourished woman in acute distress. The blood pressure was 120/80, temperature 36.7c (98 F), weight 58.9 kg. (130 pounds), and height 156.21 cm (61.5 inches). The abdomen was flat, with generalized tenderness but free of mass. Left lower quadrant guarding, rebound tenderness and hyperactive bowel sounds were noted. Pelvic examination showed a moderate amount of dark brown drainage from a cervix free of lesions. The anterior uterus leaned to the right, was normal in size and shape and very tender on manipulation. The left adnexal area was exquisitely tender with no palpable mass. Culdocentesis revealed no free fluid.

The diagnosis was peritoneal irritation secondary to hemoperitoneum from either ectopic pregnancy or ruptured endometrioma. Emergency surgery was arranged.

Laparoscopy showed the left adnexa to be deep purple in color, swollen and lodged in the cul-de-sac. It appeared to contain an unruptured tubal pregnancy. The mass was found to be the fallopian tube, 11 cm (4.33 in.) in length, curved in horseshoe fashion. It was not adherent to the uterus. The mesosalpinx was twisted with its vessels thrombosed. The specimen was removed by clamping the pedicle and doubly ligating it.

The hospital course was uneventful, and the patient was discharged on the fifth postoperative day.

The pathology report revealed acute and chronic salpingitis with areas of granulomatous inflammation. Special stains for acid-fast and fungal organisms were examined but gave negative results.

Conclusion

This case is presented to suggest the possible relationship of torsion of the fallopian tube to hysterosalpingograph using an oil base medium. Since the patient's tube was congenitally abnormal, granulomas may have formed from persistence of the lipid base medium, the long-standing inflammation finally causing torsion due to the diseased tube's increased bulk.

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▶ Dr. Oberdorfer, 1501 San Marco Boulevard, Jacksonville 32207.

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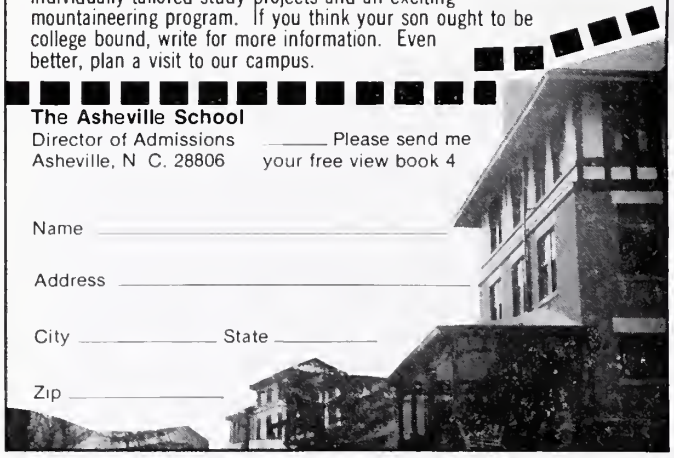

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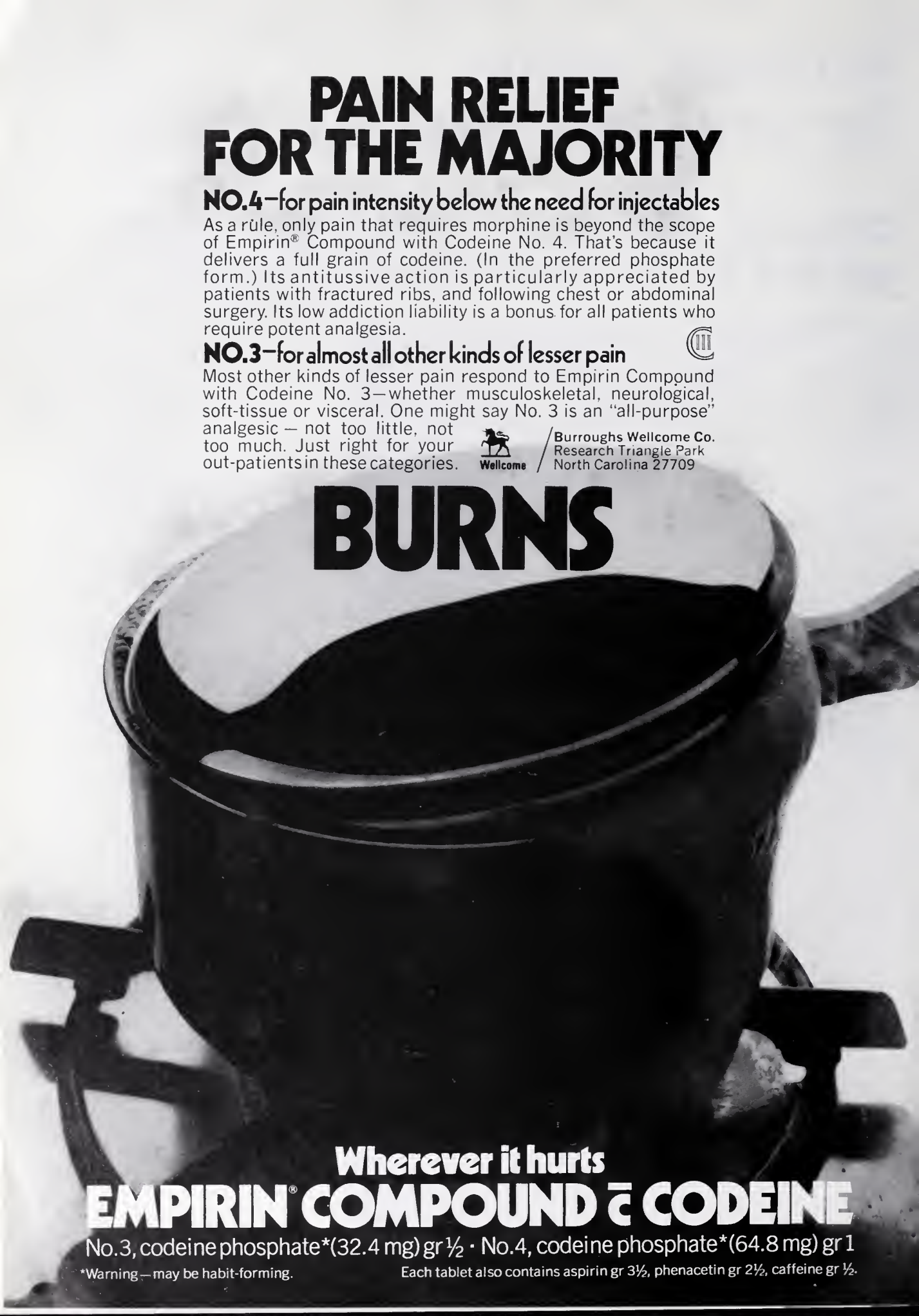

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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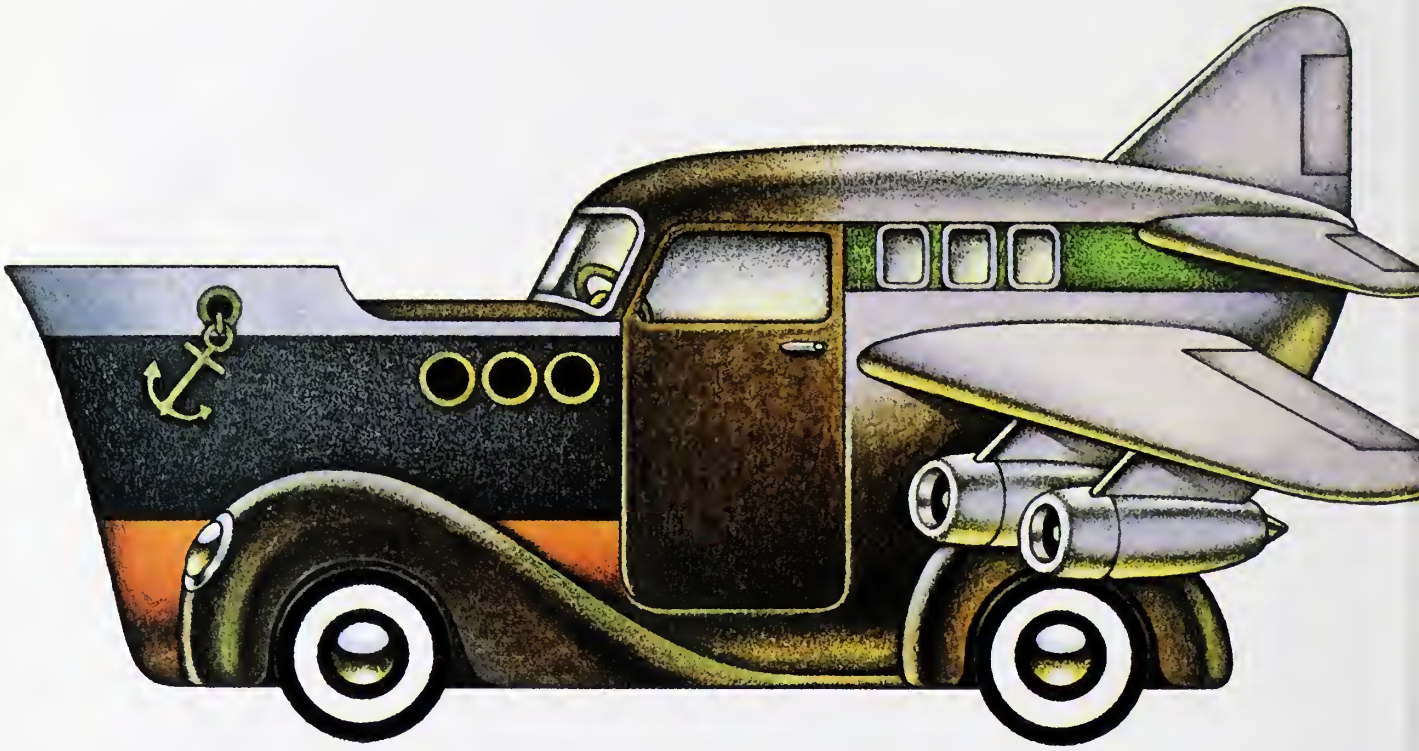

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Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

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Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, hypothermia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.

b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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Special Article

Analysis of Discharges — Pinellas County Methadone Maintenance Program

George E. Page, M.D.

Abstract: With the criteria of a successful return to a drug free life, 111 discharged patients from a methadone maintenance clinic were evaluated. It was found that 44 (39.6%) detoxified successfully. Eleven patients were lost to follow-up after discharge. The 33 who were followed were living drug free lives (29.7%).

A critical subjective evaluation by the staff prior to detoxification was found to be the most accurate predictor of success. A complete life style change on the part of the patient was found to be the most accurate objective predictor of success.

The Pinellas County Methadone Maintenance Program (PAR, Inc.) opened in the Largo area in November 1971 with a capacity for 40 clients. Early in 1973 the program was moved to the Bayfront Medical Center in St. Petersburg where a similar program had recently been established. The present location is one that provides easy accessibility to both the black and white communities and has approximately equal representation from each group. The program has expanded rapidly and presently serves 140 heroin addicts. In March 1974 the charts of all clients discharged between January 1, 1973 and February 28, 1974 were reviewed with these data obtained.

239 clients were discharged.
111 of these were on the program more than 2 months. (only those on the program more than 2 months were included in this analysis).
44 (39.6%) detoxified successfully.
11 of these 44 were lost to follow-up.
33 (29.7%) detoxified successfully and were drug-free at follow-up.
15 (13.5%) of the 111 clients entered drug-free aftercare.
13 of these 15 (87%) were considered successful detoxifications with follow-up.
67 (60%) failed to attain drug-free status at discharge.
16 (24%) of the 67 returned to the program for recycling.
11 (10%) left the program abruptly without a detoxification or a transfer; one of these is a known success.
21 (19%) clients were discharged with clinic approval. All 21 were successful.
90 (81%) were discharged without clinic approval; of these, 23 (25.5%) were successful.
32 (28.8%) showed a lifestyle change prior to detoxification. Of these, 26 (81%) were successful.

The average age of the 111 clients was 24.5 years.
The average age of those successfully detoxified was 25.3 years.
The average length of stay on the program was 6.8 months for failures, 10.3 months for successes.
There were 3 known deaths, one while on the program, two after discharge.
During July 1973, 17 clients were transferred to the Tampa program.
If the above figures are correct for this:
46% were detoxified successfully.
35% were detoxified successfully with follow-up.

Discussion

It was believed that two months was a minimum time for the program to be effective. Therefore, only clients on the program two or more months were included in the analysis. The 128 clients not included for the study represented in large part those who applied to the program but did not follow through. The remainder represented those who requested a "21-day detox" or were eligible only for a "21-day detox" under government guidelines.

People applying for methadone maintenance must meet rigid criteria which prove that they were addicted for at least two years, continuously. These criteria prevent the addiction to methadone of people who were not previously addicted to opiates. These people are often given "21-day detoxes" and, therefore, did not meet the two month criteria to be included in this study.

Others came to the program to satisfy legal requirements. Judges and probation officers often insist that their charges be enrolled in the pro-

gram as an alternative to prison. When the client has demonstrated his compliance, he often "splits" knowing that the confidentiality laws prevent us from notifying the court. Others leave us because they feel our rules are too strict or when they find that our purpose is not to provide them with a cheap narcotic "high." These short term clients represent many man hours of wasted intake procedures, inasmuch as, to the best of my knowledge, only one was successful in remaining drug-free.

"Discharged with clinic approval" represents a subjective category. Clients were placed in this category or out of it, by me, after careful review of their charts following discharge. Many factors were taken into account in making the decision. "Dirty urines," when analyzed for drugs, lifestyle changes, attitude on the clinic program, absences from the clinic appointments, self-reliance, willingness to be gainfully employed, ability to keep a job, reality of goals, law abiding behavior and general appearance were all taken into consideration. If, in weighing these factors prior to detoxification, I felt that the probability of a successful drug-free life was good, he was listed as "discharged with clinic approval." If I felt that he was weak in one or more of these areas prior to detox, I listed him as "discharged without clinic approval."

As the report shows, all 21 that were listed as "discharged with clinic approval" were successful in becoming drug-free. This overall subjective judgment would seem to be the most accurate method of choosing who should be detoxified. However, of the remainder, about a fourth successfully became drug-free. Thus my policy of not discouraging anyone who is intent on detoxification would seem to be valid.

Of the 111 discharges, 32 had shown a definite lifestyle change which was apparent to the staff. This included such things as becoming gainfully employed, or going to school, supporting and caring for his family and turning away from his old friends of the street. This was the best single objective predictor of success and proved to be correct in four out of five cases.

The single death while on the program was due to staphylococcal septicemia and meningitis. This client had been on the program four months at the time of death. While on the program, urine specimens indicated that he used cocaine on occasion and it is believed that the infection was probably the result of his self-administered injections.

The two deaths following discharge resulted from heroin overdosage. This illustrates a hazard that detoxified addicts face. If addicts return to heroin after being drug-free, they often return to their former dosage not realizing in spite of warnings that they can no longer tolerate their previous requirement.

I don't wish to leave the impression that I think these figures represent the final score. Doubtlessly, some of the "successes" will turn to drugs in the future. Follow-up times were necessarily very short (from two weeks to one year). Further, there is much evidence that narcotic addiction, like alcoholism, is a chronic recurrent disease. However the one quarter of our failures who have already returned for recycling is encouraging. Other clinics have found that the returnees have a higher rate of success than first timers.

In arriving where we are, there have been many severe disappointments, e.g., the two deaths from overdose in detoxified patients. No doubt there will be many more disappointments. Although the figures show a higher rate of success than I had expected, failures far outnumber the successes. Even so, methadone maintenance is by far the best form of treatment for narcotic addiction yet devised.

▶ Dr. Page, 5838 9th Avenue North, St. Petersburg 33710.

The hero is one who kindles a great light in the world, who sets up blazing torches in the dark streets of life for men to see by. The saint is the man who walks through the dark paths of the world, himself a light.

Felix Adler

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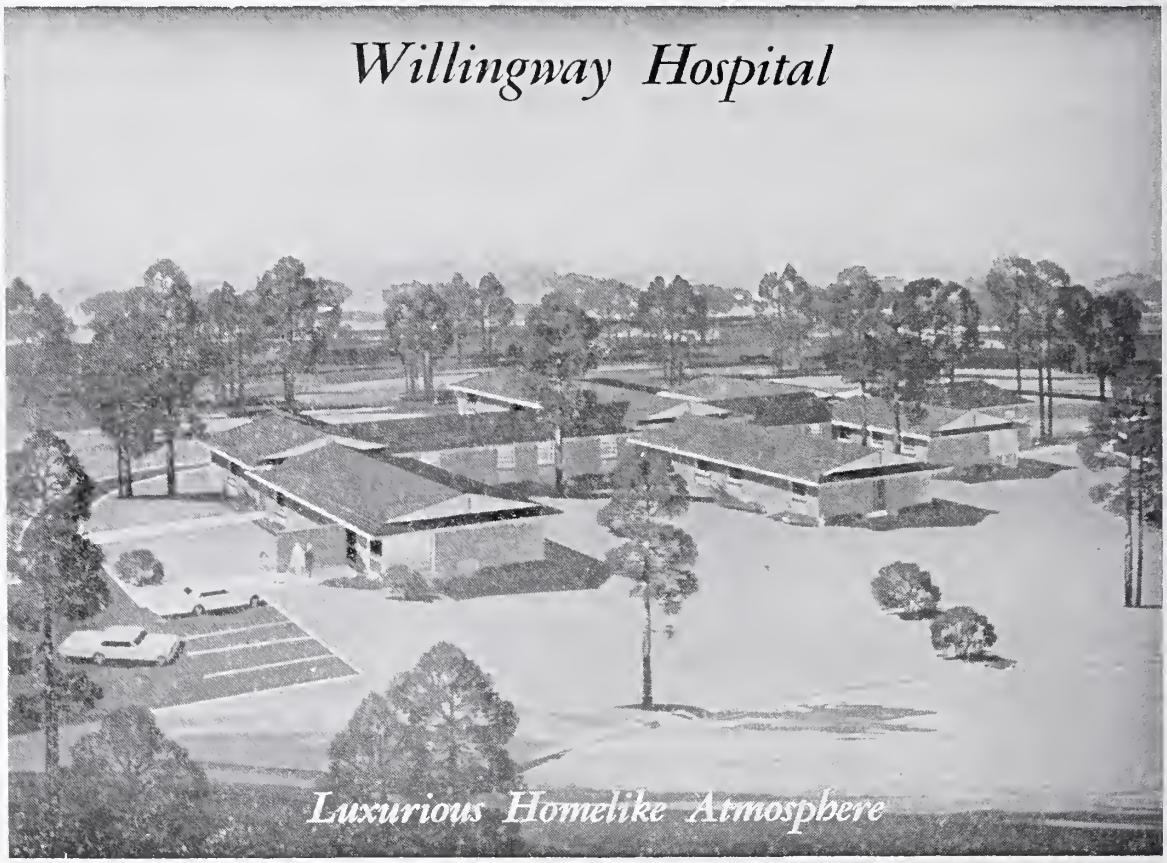

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Dorothy R. Mooney
Administrator

Member Georgia Hospital Association

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC.
Deerfield, Illinois 60015

Editorials

Thanks for the Memories

In no time at all, five years have come and gone while month after month a rough draft layout of the Journal has been sent to our printer who put it in proper form to mail out over the state. Looking back, the five years are much more intangible than 60 issues and in Dr. Roget's Thesaurus under the word intangible one finds phrases like "such stuff as dreams are made of," and "figment of the imagination," and words like "apparition," "illusion," and even "deception." The Journal has been all of these, though more of the former and less of the latter, I hope. For in spite of the hard work, doublechecking and proofreading by the full time staff and editors, errors occasionally have been included. They, however, are those of the mind and not the heart, for it has been the aspiration and intent of all those working on the Journal that it will be better every month, having something that will appeal to every reader, and at the same time serve as a media of communication for the FMA.

I am grateful to the five presidents and the Board of Governors for their confidence. I am grateful to the assistant editors and all the consulting staff for their help and encouragement. I am grateful to our contributing authors and to all those readers who have written offering advice and encouragement. Especially do we all owe a debt of gratitude to Louise Rader and Ed Hagan for their untiring day-to-day efforts to assure that a Journal is published each month.

To physician observers the Journal represents the FMA, being its conscience, its voice, its meetings and its history, presenting tangible evidence that the FMA is a viable organization, and each month reminding its readers that the FMA is working for them. To lay viewers the Journal represents the values put on the art of the practice of medicine by the profession in Florida.

Perhaps more than a few of the over 10,000 FMA members fail to read the Journal, but that is the very reason why it should be more attractive, filled with more scientific articles, poems, pictures, and news of physicians and our medical schools. The Journal's potential is limitless, besides the Journal is an extension of the President and his Board, giving them an opportunity to speak to the entire membership each month.

As one in authority of a periodical representing the establishment, an editor needs the computer-like brain of an accountant, the soul of an artist, the ability of a writer, the availability of a slave and the ideals of a crusader, yet he must also be an honest seeker of truth and an advocate for his readers, the busy private practitioner, the neophyte scientific writer and his fellow FMA member who wants to know what the Association is doing for him. The new editor, Gerry Schiebler, is all this and more. He is a well organized, practical academician, who has the ability to inspire his students and his colleagues to greater things. He is an articulate friend of organized medicine and can but add new lustre to the Journal. Here's wishing him much success in this new endeavor.

Thanks for reading the Journal.

C.M.C.

Coronary Artery Surgery

For several decades surgeons searched for a means to increase blood supply to the symptomatic ischemic myocardium. Beck and others used various forms of omentopexy, myopexy and other techniques but with little success. The Vineberg procedure utilized internal mammary artery implantation into the myocardium and represented the first method that actually increased the blood supply to the cardiac muscle. This technique failed to produce consistently satisfactory results. Vineberg's pioneering efforts, however, refocused attention on a major problem and probably was the stimulus responsible for the final breakthrough. Thus, in 1966 surgeons at the Cleveland Clinic devised coronary artery bypass or "jump graft" surgery. This would have been an exercise in futility if Sones in 1958 had not developed a relatively safe, satisfactory and reproducible method of visualizing the coronary arteries.

Coronary angiography became invaluable in determining the extent of coronary artery atherosclerotic occlusive disease and helped make aortocoronary artery bypass a frequently performed surgical procedure.

About 20% of patients who survive acute myocardial infarction may become potential candidates for myocardial revascularization surgery. In considering their best management, one must weigh the short and long-term (up to five years) results of surgery, operative morbidity and mortality and cost involved, compared with results of optimum medical management. Obviously medical management is preferable if it can provide comparable results.

Increasing or uncontrolled (unstable or preinfarction) angina, definitive diagnosis of atypical chest pain suggesting angina, uncontrolled arrhythmias secondary to coronary disease, otherwise unexplained congestive heart failure, severe persisting angina following myocardial infarction, and occurrence of mild angina at an early age with a family history of coronary artery disease may be considered indications for coronary angiography. Bypass surgery is recommended when study shows 75% or greater occlusion of one or more major coronary vessels which is producing severe uncontrolled symptoms and existence of reasonably patent distal arteries together with reasonably satisfactory myocardial function. Additional procedures may also be performed in the presence of other symptomatic hemodynamically significant lesions.

We suggest a more aggressive approach in young patients with angina and severe occlusive lesions. It is most impressive after surgery to observe a young or middle-aged individual become symptom-free, return to his former position and again support his family. We cautiously recommend coronary artery surgery in patients past 65 years of age. Risks are much greater and results often less gratifying.

The surgical technique varies only slightly with teams. Extra-corporeal circulation is necessary during at least a portion of the bypass procedure which usually consists of using the saphenous or other accessible vein or a small artery that can be sacrificed as a free graft to bypass blood from the root of the aorta to a coronary artery distal to the obstruction. Some prefer to use the internal mammary arteries as a "swing down" graft leaving its proximal origin intact. Flow through the graft should be determined by an appropriate flow meter and/or intraoperative coronary angiogram, preferably the latter.

Operative morbidity and mortality increase with extent of occlusive disease, extensive surgery, and prolonged extracorporeal circulation time, and increase or decrease with selection of patients for surgery and experience of the surgical team. The risk is higher when surgery is performed less than eight weeks after myocardial infarction, and resection of a myocardial aneurysm, septal defect closure, or valvular corrective surgery are also necessary. Immediate postoperative morbidity is not insignificant. Hemorrhage, wound infection, pericardiotomy syndrome and hepatitis are some of the not uncommon complications. The operative mortality rate is usually about 5% to 6% in most large series of patients.

Occlusion either by thrombosis or endothelial proliferation occurs in about 20% of vein grafts by the end of two years, mostly during the first year. Patients may be operated upon again if one or more grafts become occluded and severe symptoms recur.

Results from surgery vary with the degree of occlusive changes and presence of other cardiac disease processes. The best results follow single

or two vessel disease which requires only one or two grafts. Results cannot be determined on a clinical basis alone and coronary angiography should be repeated by the end of two years even in patients who do not have a recurrence of symptoms, otherwise graft patency statistics will remain incomplete and uncertain. To obtain the best results following surgery, we believe that a strict medical regimen is very important including elimination of suspected risk factors and a change in lifestyle—though admittedly little is known of the etiology and natural history of arteriosclerosis.

Coronary artery bypass surgery is of great value in selected patients who have increasing or incapacitating angina which is not adequately controlled with medical measures and in whom the left ventricular function is reasonably well preserved. Procrastination and delay may result in a myocardial infarction or other degenerative changes from myocardial ischemia rendering the patient no longer salvageable.

DeWitt C. Daughtry, M.D. and
Luiz C. Kuntz, M.D.

Miami

Doctor, Mark These Dates on Your Calendar:

April 23-27, 1975

101st Annual Meeting

Florida Medical Association

Americana Hotel

Miami Beach

Up to 22 hours of mandatory credit under the FMA Continuing Education Program may be earned by attendance at the scientific sessions.

IMPORTANT

The exhibit hall will be open at noon on Wednesday, April 23. Please have your art exhibits for the Woman's Auxiliary Annual Benefit Art Show registered and on display by 3:00 p.m. Judging will be done on WEDNESDAY, after 4:00 p.m.

Approved CME Meetings

Neonatal Care — 1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conference (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolaryngology (Arranged), University of Miami School of Medicine*

Grand Rounds in OB-Gyn. (Friday) 8 a.m., Conference Room, Second Floor, Tampa General Hospital, Tampa

Consultant Teaching Seminars, Family Practice (Weekly, Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

Cardiac Conference (Tuesday) 4:30 p.m.-5:30 p.m. North Florida Regional Hospital In-Service Classroom, Gainesville

Clinical Pharmacology Lecture Series, 8:30 a.m., 4th week of each month, Sept. 1974—May 1975, Memorial Hospital, Hollywood

Tuesday Evening Lecture Series, Department of Anesthesiology, Time: 5-6 p.m. Nov. 19; Dec. 17; Jan. 21; Feb. 11; Mar. 11; Apr. 15; May 13, Jackson Memorial Hospital, Miami

Visiting Professor Schedule, Department of Anesthesiology, University of Miami School of Medicine, Miami* — Nov. 18-20; Dec. 16-18; Jan. 20-22; Feb. 10-12; Mar. 10-12; Apr. 14-16; May 12-14

Weekly Teaching Conferences: Radiology, Wednesday, 8:15-9:15 a.m.; Pathology, Thursday, 11:00-12:00 noon; Staff Conference, Friday, 8:15-9:15 a.m.; Variety Children's Hospital 6125 S.W. 31st St., Miami 33155

Family Practice Conference (Tuesday), Bayfront Medical Center Conference Room, St. Petersburg

Neurology Workshop (Wednesday), A. Vance Morgan Educational Center, South Miami Hospital

Pulmonary Disease Processes (Wednesday), South Miami Hospital, Miami

Medical/Surgical Conference (Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Hematology/Oncology Conference (Every other Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Medical Office Management (Every other Thursday), Halifax Hospital Medical Center, Daytona Beach

Dialogue (Friday), A. Vance Morgan Educational Center, South Miami Hospital

Clinical Pathological Conference (Every 3rd Friday), A. Vance Morgan Educational Center, South Miami Hospital, Miami

Saturday Morning Chest Conference, Physicians' Library, Alachua General Hospital, Gainesville

ORGANIZATION

Our Retiring President

THADDEUS M. MOSELEY, M.D.

In 1974 the century old ship, "Organized Medicine of Florida" was tossed and buffeted by the hail of HMO's and the squalls of HEW. In mid-voyage, its fiscal decks awash with seas of red ink, the shoals of PSRO threatened to break it in two. Resisting the boarding parties of government intervention with the help of FLAMPAC, FPA and CME, its able captain, supported by FMA officers and crew members, has kept it on course and presents it now shipworthy for inspection, support and continued service.

Years ago a wise poet wrote, "do not be too timid and squeamish about your actions, all life is an experience. The more experiments you make the better. What if they are a little coarse and you may get your coat soiled or torn? What if you do fail and get fairly rolled in the dirt once or twice? Up again; you shall never be afraid of a tumble." Thad, all FMA is grateful to you for having done a great many things this year, for being the forceful, persuasive spokesman for us, for taking a year out of your life away from your family and your practice, and spending it in our behalf. Another writer once said, "the tendency to persevere to persist in spite of hindrances, discouragements and impossibilities—it is this in all things distinguishes the strong soul from the weak," and for your strength of character, Thad, your dedication, and your many, many hours of service, we are grateful.

C.M.C.

In Memoriam

Robert E. Zellner, M.D.
1915-1975

Robert Earl Zellner, M.D., of Orlando, 82nd President of the Florida Medical Association, died February 23, 1975. Medicine lost an erudite, energetic leader whose special interest was general surgery and continuing concern Blue Shield of Florida which he served as chairman of the Board of Directors.

Dr. Zellner became active in the Association in 1951 as chairman of the Committee on Insurance. He had been practicing in Orlando five years. In 1953 he served as chairman of the Committee on Medical Economics and member of the Advisory Committee to Blue Shield. He was made chairman in 1959 and at the same time chairman of the Committee on Fee Schedules. The following year he was appointed to the Board of Governors and in May 1961 was chosen President-Elect. Later he became a delegate to the American Medical Association, a position he held at his death. He served the Orange County Medical Society in many capacities including the presidency.

Dr. Zellner had a simple explanation for devoting his time to organized medicine. "It has enabled me to get to know and to count people as my friends." Medicine had introduced him, he said, to the "finest people on earth," and this had brought about a "deep feeling of appreciation and obligation."

Something of his philosophy of practice and religious faith shows in his further comments. "Any doctor worthy of the name must have a full measure of compassion in his heart and love for his profession and for his patient. In the long run the best loved and most successful doctor is usually the one who gives the most of himself." Admitting that love and compassion were difficult to define, Dr. Zellner stated that the Apostle Paul gave a good illustration in his first letter to the church at Corinth. He quoted these verses with the familiarity that would come from serving the First United Methodist Church of Orlando as a trustee.

He showed concern for the future of his profession. "If our sons are to have the opportunity of enjoying the great satisfaction of practicing as we have, we cannot permit Medicine to become federalized, unionized, mechanized or in any other way impersonalized."

He held definite opinions and expressed them. "I would like to make it crystal clear that I dislike fee schedules. The implication of absolute equality of professional ability throughout the profession is obviously erroneous."

"As long as you can persuade some long-suffering doctor to act as your representative in the administration of Medicare, you had better do it."

"Being right is not sufficient in itself. If one is so obnoxiously right that he loses his friends, he is likely to lose his cause."

He admitted that Blue Shield operations were not perfect. "Where things are wrong, I will use what influence I have to see that they are corrected. I don't know that I have any answer to the dissatisfaction and criticism other than to provide the greatest possible exposure to the inner workings and operations. Blue Shield has nothing to hide; on the contrary we have a great deal of which to be proud."

At the end of his term as Association President he talked about hope: ". . . . hope that my best has been good enough, the confidence of my friends justified; hope that I have not earned a comment similar to the preacher's upon the loser in a cutting scrape: 'He fit a good fight but his razor was dull.' "

Dr. Zellner concluded more than a quarter century of looking after his patients and serving his community. He is remembered for many contributions, not the least a friendly smile, warm greeting, "I'm Bob Zellner," and firm handclasp.

He and Mrs. Zellner were married in 1938, two years before he was graduated from Rush Medical College of the University of Chicago. Subsequently they moved to Atlanta where Dr. Zellner served an internship at Grady Memorial Hospital and to Orlando for his residency at Orange Memorial Hospital. They grew up and attended high school together in Lakeland. Their daughters are Judy and Cynthia and son, Robert Jr.

Urgent Memorandum to all FMA Members

Professional Liability Insurance

The Board of Governors has been advised by the attorneys for Teledyne and the ARGONAUT INSURANCE COMPANY OF THEIR INTENTIONS TO INCREASE THE PREMIUMS FOR THE 5,500 PHYSICIANS INSURED UNDER THE FMA PROGRAM BY APPROXIMATELY 94.8%, effective April 1, 1975, and TO TERMINATE ALL POLICIES December 31, 1975. This is in addition to the 96% increase which became effective January 1, 1975.

BOTH OF THE ACTIONS ARE IN DIRECT VIOLATION OF A LEGAL CONTRACT WHICH THE ARGONAUT INSURANCE COMPANY ENTERED INTO WITH THE FMA WHICH DOES NOT TERMINATE UNTIL DECEMBER 31, 1977.

The Board of Governors reviewed this subject on March 8, 1975, and by unanimous vote, reaffirmed its decision that UPON BREACH OF CONTRACT BY THE ARGONAUT, THE FMA WOULD ENTER SUIT IN THE APPROPRIATE COURT and pursue this breach of contract as vigorously as possible.

It further reaffirmed that in the event that coverage is not available from conventional sources that FMA will ORGANIZE a medical liability mechanism. This mechanism can only be ACTIVATED with adequate participation by physicians and only upon IMPLEMENTATION of specifically stated statutory relief.

The Board further reaffirmed to specifically request the Florida Legislature to enact legislation at the earliest possible date to:

1. PLACE A LIMIT ON THE AMOUNT OF LIABILITY that could be awarded an individual on account of tort or negligence.

2. A. PLACE AN ABSOLUTE LIMIT ON THE STATUTE OF LIMITATIONS of two years.

   B. Define informed consent.

   C. Providing NO GUARANTEE OF RESULTS of treatment may be valid and enforceable UNLESS IN WRITING.

   D. Define Res Ipse Loquitur.

3. Provide that the courts establish MANDATORY ARBITRATION panels requiring a preponderance of evidence for tort or breach of contract or negligence. Arbitration panel evidence would be admissible in court in the event of trial.

Continue to support previously adopted legislative objectives regarding placing a limitation of CONTINGENCY FEE arrangement in negligence cases and prohibiting the Ad Danmum Clause.

YOU WILL BE ADVISED IMMEDIATELY OF ANY ACTIVITY WHICH WILL AFFECT YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE OR PREMIUMS.

PLEASE CONTACT YOUR LEGISLATORS!

We Need Your Help!

To Update the 1971 Relative Value Study

The 1974 House of Delegates of the Florida Medical Association instructed the Committee on Relative Value Studies and Fee Schedules to update the 5-digit 1971 Relative Value Study. The Council on Medical Economics has been instructed by the FMA Board of Governors to petition hearings before the Workmen's Compensation Commission to present evidence for the need to raise Workmen's Compensation fees. In order to accomplish these two missions, the Relative Value Committee will conduct a survey of all the members of the Florida Medical Association to determine their usual charge for the most common procedures performed for Workmen's Compensation and the most common procedures in each specialty, including family practice and general practice. Representatives of Blue Shield tell us that around 200 procedures represent 90% of the procedures performed by Florida physicians.

The questionnaires are designed for 5-digit coding with descriptors taken from the 1974 California Relative Value Study, which is the most complete and up-to-date descriptors available at this time.

It is most important that every member of the Florida Medical Association fill out his questionnaire to accurately reflect his current fees in order that we may update the 1971 Relative Value Study and obtain data to present to the Workmen's Compensation Commission. The information must be reliable and we ask your permission to allow Doctor Howard, our statistician or one of his staff, to come into your office and check your records to verify the fees. In this manner, Doctor Howard is able to testify under oath before the Workmen's Compensation Commission or other third party agencies that the Relative Value Study is accurate and reliable.

Representatives of Blue Shield tell us that if the Florida physicians will use the 5-digit coding and descriptors that Blue Shield and Medicare claims can usually be processed in half of the present time.

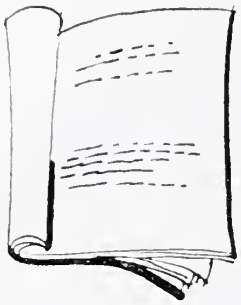
You will receive this questionnaire on or around April 1. Alert your secretary to be on the lookout for it. Please complete it accurately and return it promptly. This should not take more than 10 to 15 minutes of your time. We need your help!

Charles K. Donegan, M.D., Chairman
Committee on Relative Value Studies
and Fee Schedules

Those who favor a federal health program would do well to examine the Indian Health Service carefully, even though the problems of a national program would dwarf those of the limited IHS effort. It's true enough that IHS is underfinanced, but given economic reality any but a bare-bones national health program would inevitably be similarly underfinanced, understaffed and inadequate. Moreover, lack of money alone is not sufficient to explain the abysmal Indian health statistics or the dismal record of the government's fling with a federal health program.

The principal reason for that failure lies elsewhere, bound up with the limitations inherent in trying to solve complex social problems with political formulas. This failure of the federal government to adequately treat the health needs of fewer than a half million Indians inspires little confidence that it would do any better job treating the health needs of more than 200 million other Americans.

Submitted by Joel Mattison, M.D., Tampa and reprinted from the September 30, 1974 Wall Street Journal.



Others Are Saying

No Quick or Cheap Victories

PSRO has been much in the news. We have been bombarded by tens of thousands of words which, in the final analysis, contain all too few facts on which we can make a logical judgment. Basically, PSRO involves review, supervised nationally, but carried out locally, of all patients covered by government programs. Our choice, at this moment, seems to be whether we will accept the law and abide by it, thereby carrying out the review ourselves, or whether we will defy it and allow others—not necessarily our peers—to review the practice of medicine.

Organized medicine, over the country, has adopted one of the two approaches noted above. The majority of medical societies have decided to work within the law, and attempt to participate in its implementation. At the same time, energetic and continuing efforts will be made to modify its more odious precepts.

Some medical associations, at the local or state level, have elected to defy the PSRO Law, and work for its repeal. One fact should be noted in considering the latter course. This particular bill passed the Senate with one dissenting vote. Our legislators have told us that the chances of repeal are nil. On the other hand, they feel that organized medicine has an excellent chance of modifying the law, and should pursue this course vigorously.

HCMA has in fact been busily engaged in efforts to bring about some of the changes considered necessary to make our local situation one with which we can live and make workable. The state PSRO area designations originally made were, to say the least, inappropriate. With the cooperation of the FMA and the Department of Health and Rehabilitative Services, these areas have been changed. This took time and effort. It does demonstrate that unified action can and does produce some results, though they may not encompass the total desired.

As your current president, I feel that one basic overriding principle should be emphasized in all our future dealings with national legislation involving medicine. The changes coming in the next few years will dwarf those which have occurred in the recent past—or even the more remote past. There will be no quick or cheap victories. Our only hope is to persevere for years in every worthwhile attempt to mould and guide the many programs and changes that are to be proposed.

The old simplistic cowboys and Indians approach with quick final decisions is extinct. We must be prepared to devote our energies for the rest of our professional lives to the preservation of quality medicine with as much freedom as possible. PSRO is here, HMO's are coming on at full gallop. We should remember that history is neither a continuum, nor are its happenings forever irreversible.

Our goal, therefore, must be to preserve as much of the good aspects of medicine as possible in the firm hope that we may be able to protect its basic values and add to them in the future.

Louis E. Cimino, M.D.
Tampa

Reprinted from the President's Page in The Bulletin, Hillsborough County Medical Association, March, 1974.

for Angina Pectoris ...

A totally new and improved delivery system for Isosorbide Dinitrate

ISO-BID

(ISOSORBIDE DINITRATE) 40 mg. Capsules

SUSTAINED RELEASE THROUGH MICRO-DIALYSIS DIFFUSION...

New ISO-BID can help to reduce the frequency and intensity of angina attacks through microdialysis diffusion (controlled sustained release).

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate for up to 12 hours at a smooth, continuous, predictable, *controlled* rate. *Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables.* ISO-BID is particularly advantageous in the prevention of nocturnal angina.

Prescribe ISO-BID. There is nothing else just like it... because MICRO-DIALYSIS DIFFUSION MAKES THE DIFFERENCE.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Not intended for sublingual use. Supplied in bottles of 30, 100 and 500 ISO-BID capsules.

Consult product brochure before prescribing.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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PREMARIN. The only estrog preparation available that conta natural estrogens exclusively and meets all U.S.P. specifications f conjugated estrogens. Assurance quality for you and your patien

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BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

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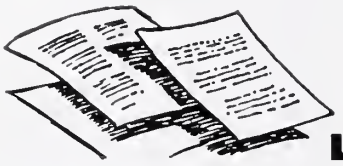


Letters

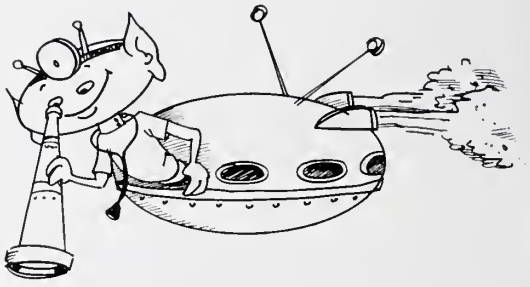
Dear Earthdocs:

Thanks for letting me write you again. I will be watching many of you at the upcoming Flatland Medical Association Meeting; meanwhile, may I pass on a few thoughts I've had recently. It has occurred to me that you earth physicians who participate in medical society leadership at the state or local level must do so at some expense to yourselves. If, as earthling management consultants compute, the physician's working time should be worth as least $60/hour to make his living and support his appropriate 50% overhead; then medical society work can be costly in earth bucks. On the other hand, perhaps medical society work takes away from activities other than medical practice. As a Roman Catholic physician once expressed it when he was donating time to health care work for the nuns, he considered those "purgatory points." In the same vein, no medical pun intended, then medical society time taken away from marriage or tennis might be considered "minus love points." There are some economic advantages, I would guess, if a physician chose medical society activity instead of owning a boat or supporting a mistress since medical society work would be less expensive by far. Perhaps even less dangerous! Before I began to observe Flatland Medical activity, I predicted in my Martian brain, that Flatland medical leaders would be doddering old men. After observing, however, I find that this is truly not the case and most of the leaders are men in their physical, and presumably their sexual, prime. Plato once proposed that leaders of the community should be old men without the ties of wives and family. I am glad to see that such is not generally the case with you Flatlanders. Being a middle-aged Martian myself, it makes me a bit proud. As written in a previous column, I have no personal experience with sexual reproduction; Martians reproduce by binary fission. However, occasionally it's fun for me to fizz a little every now and then. But being middle-aged, not as much as I used to.

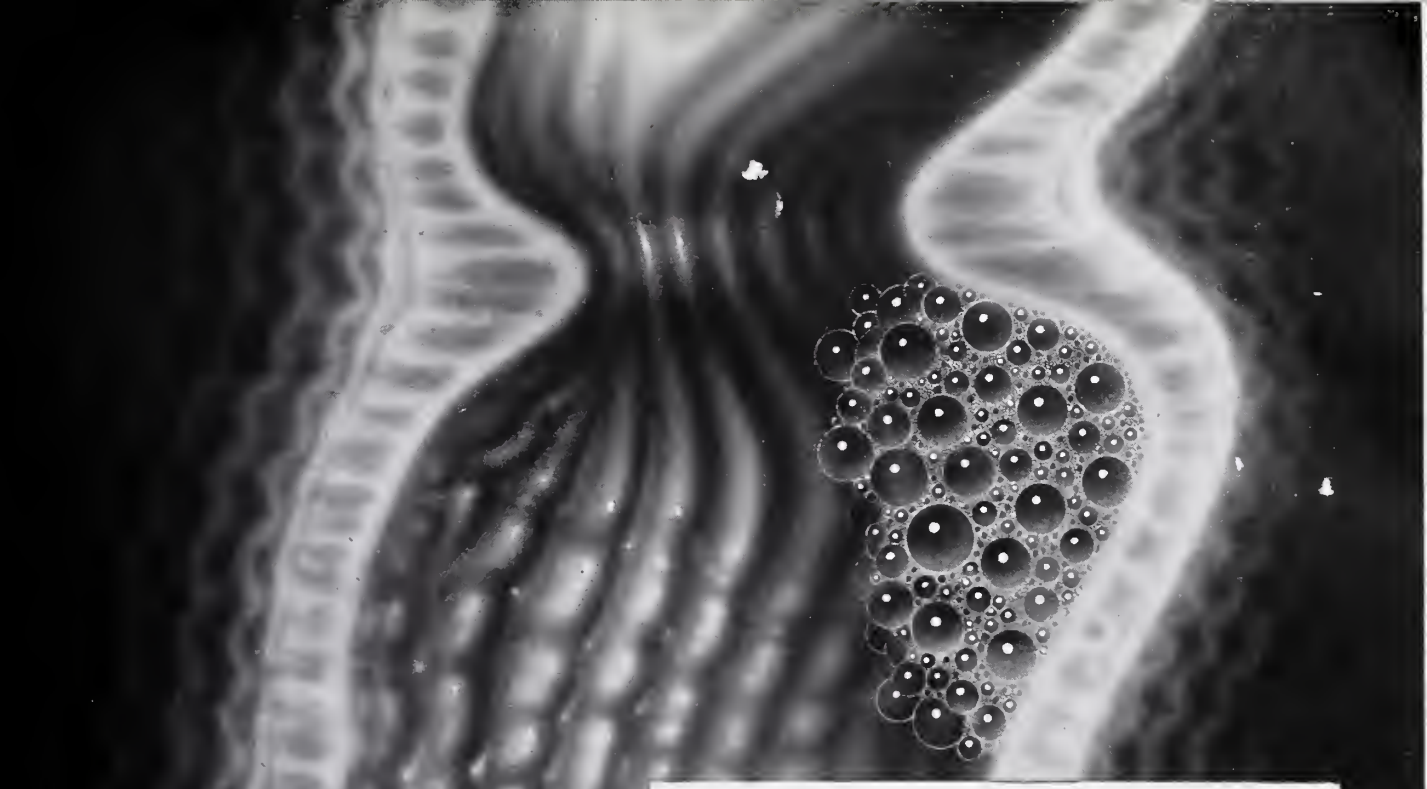
I wondered how your delegates at the special session felt passing the PSRO resolution and in raising the dues. Dues raises in the Martian world are never received happily by the membership. I hope that your Flatland earth members can understand to accomplish important FMA work in these troubled, inflated times, that funds must be supplied to do so.
See you at the FMA Annual Meeting.

Sincerely,
Martiandoc

P.S. I sent along my picture so that you might recognize me.



Martiandoc



Entrapped gas...

Silent partner of GI spasm

Painful GI spasm in the presence of entrapped gas causes even more pain and more discomfort. Yet, while spasm is relieved, entrapped gas often goes untreated.

Not so when you prescribe Sidonna. Sidonna helps release entrapped gas with specially activated simethicone, a nonsystemic antiflatulent, while also helping to relieve spasm with a traditional combination of belladonna alkaloids. And Sidonna provides mild sedation with butabarbital.

Sidonna. The therapeutic partnership approach to functional or organic GI disturbances including spastic colon, irritable bowel syndrome, gastroenteritis, gastritis, peptic ulcer and nervous indigestion.

Contraindications: hypersensitivity to barbiturates or belladonna alkaloids; glaucoma, prostatic hypertrophy, pyloric obstruction. **Side Effects:** dry mouth, blurred vision, dysuria, skin rash, constipation or drowsiness. **Dosage:** one or two tablets preferably before meals and at bedtime.

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Sidonna®

Each scored tablet contains: specially activated simethicone 25 mg., hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: may be habit forming.)

A working partnership against the pain of gas and spasm

The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology

X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

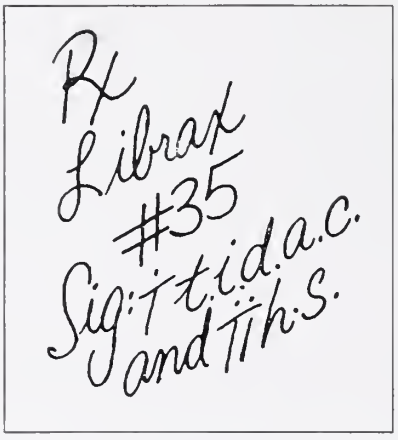
ROCHE

Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Initial therapy

The initial prescription allows evaluation of patient response to therapy.

Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan$^{T.M.}$)—bottles of 100 and 500.

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DOSAGE: One or Two Capsules daily.
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MEETINGS

Approved by FMA Committee on Continuing Medical Education

APRIL

Clinical Cardiology for the Practitioner, Apr. 3-4, Hilton Inn, Gainesville**

Family Planning Seminar, Apr. 4, Galatea Inn, Pensacola. For information: Philip B. Keitlen, M.D., Bureau of Maternal Health & Family Planning, P. O. Box 210, Jacksonville 32201

Regional Block in Modern Day Surgery, Apr. 7, University of Florida, Room M-523, Gainesville**

Seminar Session, Department of Anesthesiology, Apr. 7-11, University of Florida College of Medicine, Gainesville**

Effect of Concentration of Local Anesthetic Agents and Epinephrine on Uptake, Apr. 8, University of Florida, Room M-523, Gainesville**

The Comparison of Bupivacaine and Etidocaine for Vaginal Delivery, Apr. 10, University of Florida, Room M-523, Gainesville**

Fourth Annual Consecutive Case Study Conference, Apr. 11-12, Ponce De Leon Motor Lodge, St. Augustine. For information: George A. Anderson, M.D., 2005 Riverside Avenue, Jacksonville 32204

Fracture Bracing Workshop, Apr. 12-13, Miami*

Courses of Instruction in Coronary Care, Apr. 14-19, Jackson Memorial Hospital, Miami*

New Trends in Cancer Chemotherapy, Apr. 15, Hospital Trailer, Martin Memorial Hospital, Stuart*

▸Geriatric Medicine 1975, Apr. 16-17, Sutton Beach Hotel, Miami. For information: American Geriatrics Soc., 10 Columbus Circle, New York 10019

15th Workshop in Electrocardiography, Apr. 17-21 (note change in dates), Tides Hotel, Redington Beach—St. Petersburg. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

Advances in Endoscopy, Colonoscopy, Laparoscopy & Cannulization of Ampulla of Vator, Apr. 18, Parkway General Hospital, North Miami Beach*

Non-Hodgkins Lymphoma: Classification, Evaluation, and Therapy, Apr. 21, Broward General Medical Center, Fort Lauderdale*

Postgraduate Seminar on Arthritis and Related Diseases, Apr. 18-20, Thunderbird Motor Hotel, Jacksonville. For information: Louis M. Sales, M.D., 2522 Oak Street, Jacksonville 32204

Clinical Management of "The Poor Risk Patient," Apr. 19-20, Galatea Inn, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" St., Pensacola 32501

Program for Foreign Medical Graduation, Apr. 28 & July 24, Sheraton Four Ambassadors Hotel, Miami Beach*

MAY

25th Annual Postgraduate Seminar, May 1-3, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

An Intensive Day in Intensive Care, May 3, VA Hospital, Miami*

Seminar Session, Department of Anesthesiology, May 5-9, University of Florida College of Medicine, Gainesville**

Multidisciplinary Approach to Management of Head and Neck Cancers, May 9-10, Auditorium, St. Augustine General Hospital, St. Augustine*

Cardiological Cruise, May 10-17, S. S. Rotterdam, New York - Nassau - Bermuda - New York. For information: Tampa Tracings, Box 636, Oldsmar, Florida 33557

Family Practice Review Program, May 12-16, Gainesville Hilton, Gainesville**

The Anxieties of Doctors, May 15, Baptist Hospital, Pensacola. For information: Claude L. Brown, M.D., 176 Louiselle St., Mobile, Ala. 36607

Master Approach to Cardiovascular Problems, May 15-17, Walt Disney World, Orlando*

5th Annual Radiotherapist Clinical Research Seminar, May 15-17, Flagler Inn, Gainesville**

Radiation Oncology, Indications for and Treatment of Cancer Patients, May 16, Auditorium, Parkway General Hospital, N. Miami Beach*

The Spinal Cord Injured Patients, May 16, Miami*

Twenty Sixth Annual Seminar of the Greater Miami Pediatric Society, May 21-22, Mailman Center for Child Development, Miami. For information: Stanley D. Rosenthal, M.D., 3700 N.W. 167th St., Opa Locka, Florida 33054.

JUNE

9th Annual Workshop in Electrocardiography, June 12-17, Sheraton Sand Key Hotel, Clearwater Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg

Rehabilitation Needs of the Cancer Patient, June 16, Broward General Medical Center, Fort Lauderdale*

1975 Clinical Conference in Pre-Hospital Emergency Care, June 20-22, Orlando Hyatt House, Orlando. For information: Registrar, Pre-Hospital EMS Conference, 1919 Beachway Rd., Suite 5C, Jacksonville 32207.

OCTOBER

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach—St. Petersburg. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg.

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Arthritis and Orthopaedics, Oct. 17-19, Miami*

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According to her major
mptoms, she is a psychoneu-
tic patient with severe
xiety. But according to the
scription she gives of her
elings, part of the problem
ay sound like depression.
his is because her problem,
though primarily one of ex-
ssive anxiety, is often accom-
nied by depressive symptom-
ology. Valium (diazepam)
n provide relief for both—as
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ms associated with it are also
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rcotics, barbiturates, MAO inhibitors
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THE JOURNAL
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May Cover—Vernon B. Astler, M.D., of Boynton Beach, Ninety-Ninth President of the Florida Medical Association.

"...a more satisfactory treatment..." [1]

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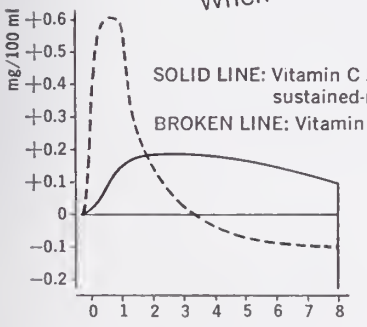

SOLID LINE: Vitamin C blood levels obtained with sustained-medication capsules (CEVI-BID).

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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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President's Page

Open Game

Keep a low profile, doctor. You are in season! There are no state or federal limits on numbers taken or the size of "the take." It is open season and there is an insurance bounty on your head. Of course, I am referring, in a timely way, to the professional liability crisis. In a broader sense I am referring to other changes involving doctors in recent months, changes like PSRO, PRO, recertification, relicensure, mandatory postgraduate hours, Medicare, Medicaid, physicians assistants, HEW, HRS, certified hospital admission procedure, Emergency Rooms and Emergency Medical Services, fifth pathways, health planning councils, foundations, foreign medical schools and graduates, and that timely darling, National Health Insurance.

There are many more for the listing, but I am certain those already mentioned are enough to gag many of you. Perhaps it is not surprising that the February 1973, Journal of the American Medical Association reported that suicides among physicians exceeded the combined deaths from automobile accidents, plane crashes, drowning, and homicide. The average suicide age for physicians was 49 years and the annual total number of deaths from this cause exceeded the size of an average medical school graduating class.

Paradoxically, the legislative and consumer attacks upon the medical profession come at a point in time when medical standards have never been higher in the history of the world.

Consider the following: U.S. life expectancy is now almost 75 years and increases progressively. Since 1920, life expectancy has increased 13 years for males and 20 years for females. Kidney transplants from well matched living donors can expect a long term survival of 85-90%. Cadaveric grafts will give a long term survival of 50-60%. Infectious disease mortality has been altered dramatically. In 1968, deaths from communicable diseases were 18% of those in 1930 and 30% less than 1950. At the beginning of 1974 there were 366,379 physicians in the United States of whom 91% were involved in the direct care of patients as their primary activity. The numbers of medical schools and physicians are constantly increasing. 16,689 physicians received initial licenses in 1973, an increase of 15% over the figure for 1972. By 1970, 181.5 million U.S. citizens (or 89% of the civilian resident population) had one or more forms of private health insurance. By 1970, 169 million Americans had

surgical expense insurance, a 44% growth for the preceding decade. Medical schools have continued to increase in number and size, while attempting to shorten the calendar years necessary to produce physicians. Still, we continue to hear almost daily about "the physician shortage," infant mortality, national schemes for health care, etc. ad nauseaum.

As long as United States citizens are plagued by obesity, air and water pollution, sedentary lives, alcoholism, vehicular accidents, poor housing, tension and anxiety, malnutrition, etc., a thousand HMOs, and a new national health scheme; more medical schools and hospitals, are not going to remedy the situation. The American medical system is pluralistic, complex, ever-changing, and has served the people well. It can continue to do so only if the aim is to change those portions of the system which need change, but not destroy a viable working system which is delivering. The liability insurance problem is beginning to destroy the health delivery system.

The medical profession is a noble one. steeped in deep rooted professional heritage and dedicated to the needs of mankind. Our profession is continuing to study and correct deficiencies in the health care system as they are revealed, yet, many alleged inadequacies are not justified when carefully reviewed and scrutinized critically. Such ongoing and unfounded charges can only serve to raise health costs, weaken the health delivery system, discourage the providers, create new and often hastily conceived and unworkable laws, and most importantly, interfere seriously with the health of the consumer. Young primary care physicians are discouraged and considering other avenues. Older doctors are being driven out of practice and into premature retirement. The ranks of those dedicated doctors remaining are further weakened and thinned.

While these words seem depressing, I submit that nothing lowers morale or destroys the system so promptly or severely as unfounded attacks on the righteous health provider.

I envision some ultimate good emerging from these happenings if they serve to bind those of us remaining together in common fraternity and cause, and to alert the populace to the danger of driving the health system, as they once knew it, to extinction.

Vernon B. Astler

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Niacinamide	10
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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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NSN 6505-00-148-6967

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ANTIMINTH®

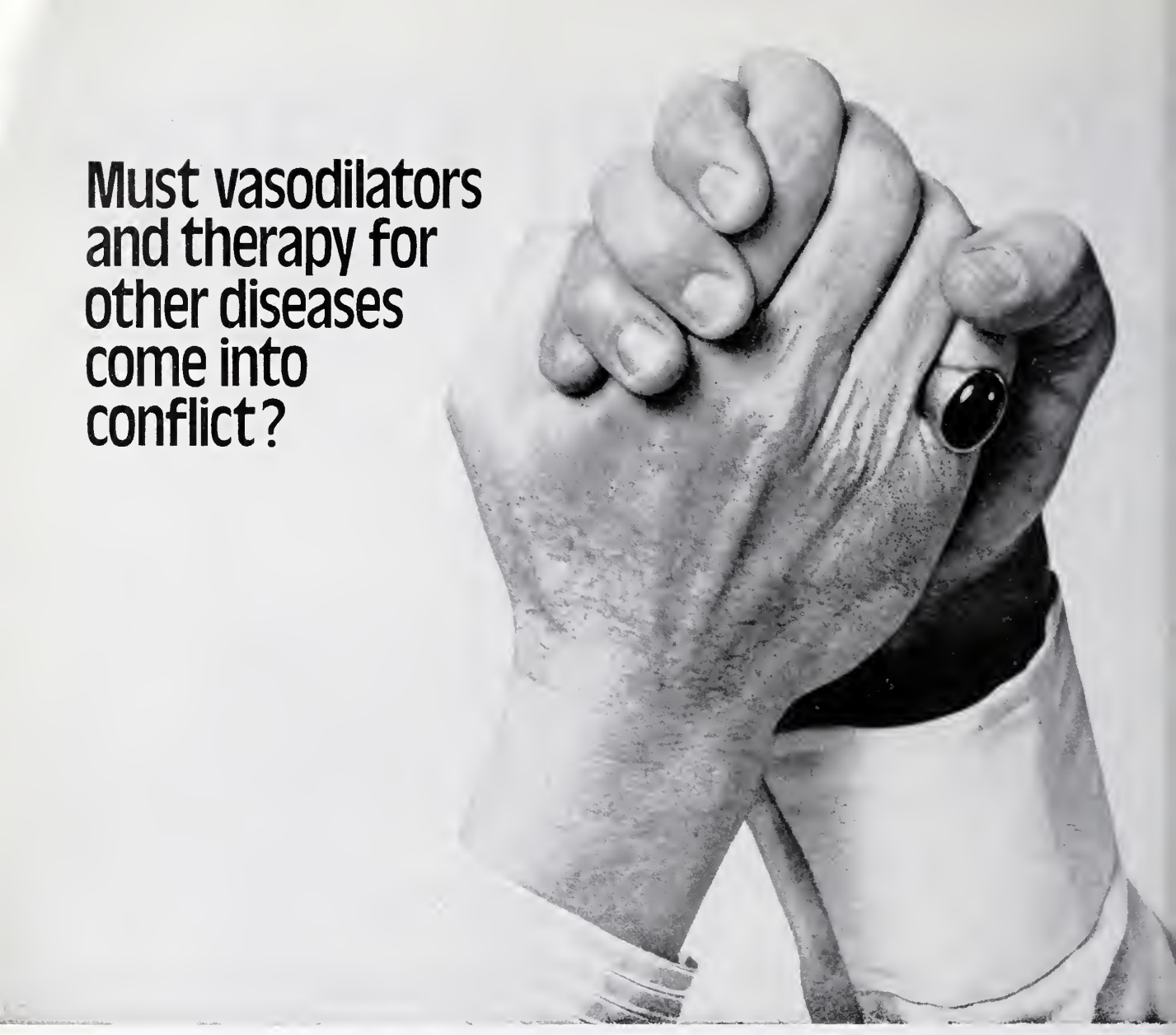
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

Please see prescribing information on facing page.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

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(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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makes sense in edema.*

either inconvenient, unpalatable, expensive potassium supplements nor special K^+ rich diets are needed as a rule. Just 'Dyazide' once or twice daily for control of edema.

fore prescribing, see complete prescribing information in SK&F literature or *PDR*. The following brief summary.

lications: Edema associated with congestive heart lure, cirrhosis of the liver, the nephrotic syndrome; roid-induced and idiopathic edema; edema retant to other diuretic therapy. Also, mild to moderhypertension.

ntraindications: Pre-existing elevated serum posium. Hypersensitivity to either component. Conued use in progressive renal or hepatic dysfunction developing hyperkalemia.

rnings: Do not use dietary potassium supplements potassium salts unless hypokalemia develops or tary potassium intake is markedly impaired. teric-coated potassium salts may cause small wel stenosis with or without ulceration. Hyperlemia (>5.4 mEq/L) has been reported in 4% of tients under 60 years, in 12% of patients over years, and in less than 8% of patients overall. rely, cases have been associated with cardiac irgularities. Accordingly, check serum potassium ring therapy, particularly in patients with susted or confirmed renal insufficiency (e.g., elderly diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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asic therapy with
onvenience for
cute nonobstructed
ystitis

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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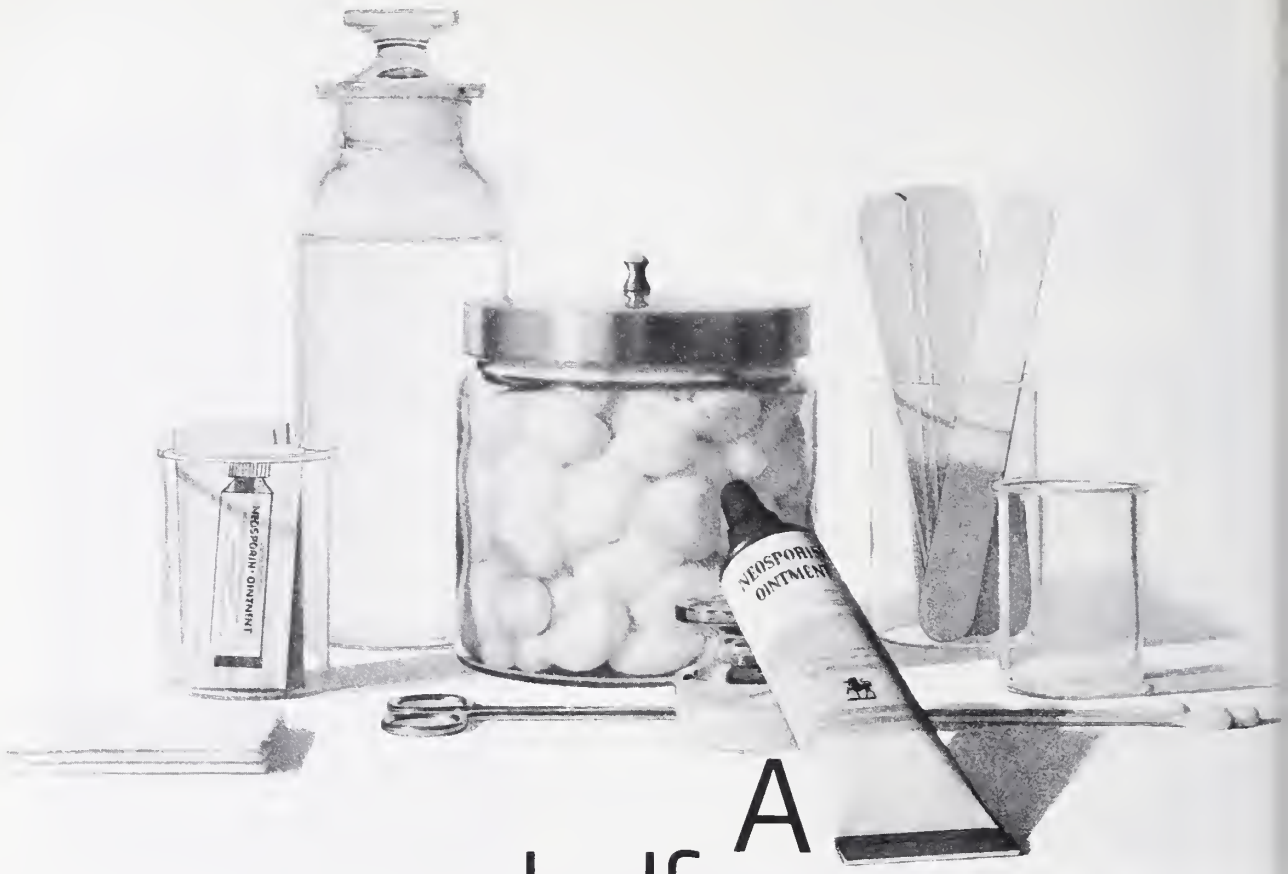
- Effective against susceptible E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis and, less frequently, Proteus vulgaris



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Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of body surface is affected, especially if the patient has impaired renal functio or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropri measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of pe allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept.

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North Carolina 27709

FLORIDA CAMP FOR CHILDREN AND YOUTH ANNOUNCES 1975 SESSION

The fourteenth annual session of Florida's Camp for Children and Youth with Diabetes will be July 13-26 at Camp Lake Swan near Melrose, Florida. Youngsters 7-20 years of age may attend camp with approval of their physicians. Those eligible for and registered with Division of Children's Medical Services may attend camp without fee and scholarships are available for others unable to pay the $200 camp fee.

In addition to an unmodified physical program which includes water skiing, horseback riding, swimming, sailing, crafts, and games, there is a complete training program in diabetes self-management and understanding. Faculty and health science students from the University of Florida; University of South Florida; University Hospital, Jacksonville; Community Colleges, and Mount Sinai Hospital of Greater Miami live and work with the youngsters.

The 1974 program accommodated 230 youngsters with diabetes, and 75 professional staff and students.

Florida physicians, nurses, and other health workers who see children and adolescents with diabetes are welcome to participate as staff members of the Camp and are encouraged to refer youngsters to the program. For information or applications, contact:

PROGRAM OFFICES: Beverly Giordano, R.N.
Department of Pediatrics, Box 739
J. Hillis Miller Health Center
Gainesville, Florida 32610
904/392-3331

MIAMI: Juvenile Diabetes Research Foundation
7525 N.W. 74th Avenue
Miami, Florida 33166
305/888-3437

TAMPA: John I. Malone, M.D.
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Tampa, Florida 33620
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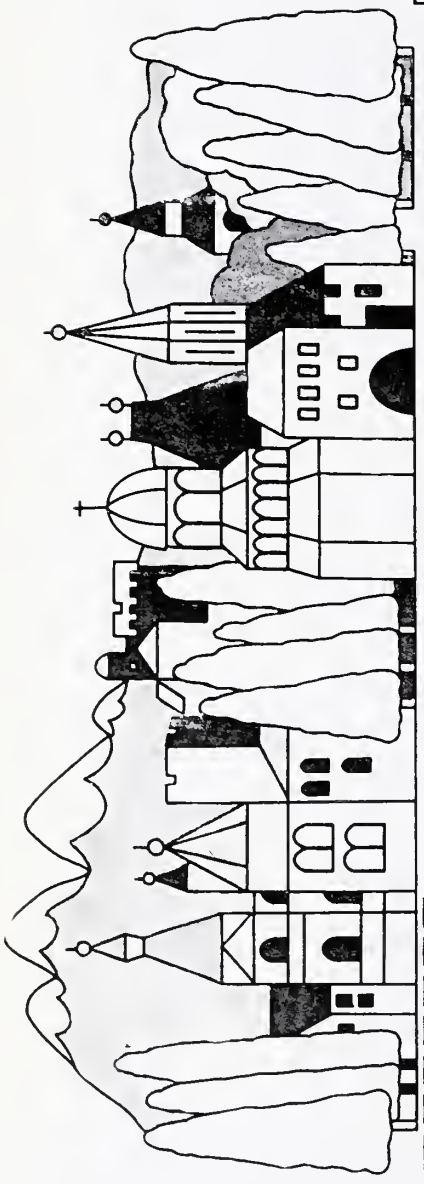

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Names _____ Address _____

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Another Non-Regimented INTRAV Deluxe Adventure

The overweight diabetic...

trapped by her own fat cells.

If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the overweight diabetic needs a drug that doesn't stimulate insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD,® phenformin HCl.

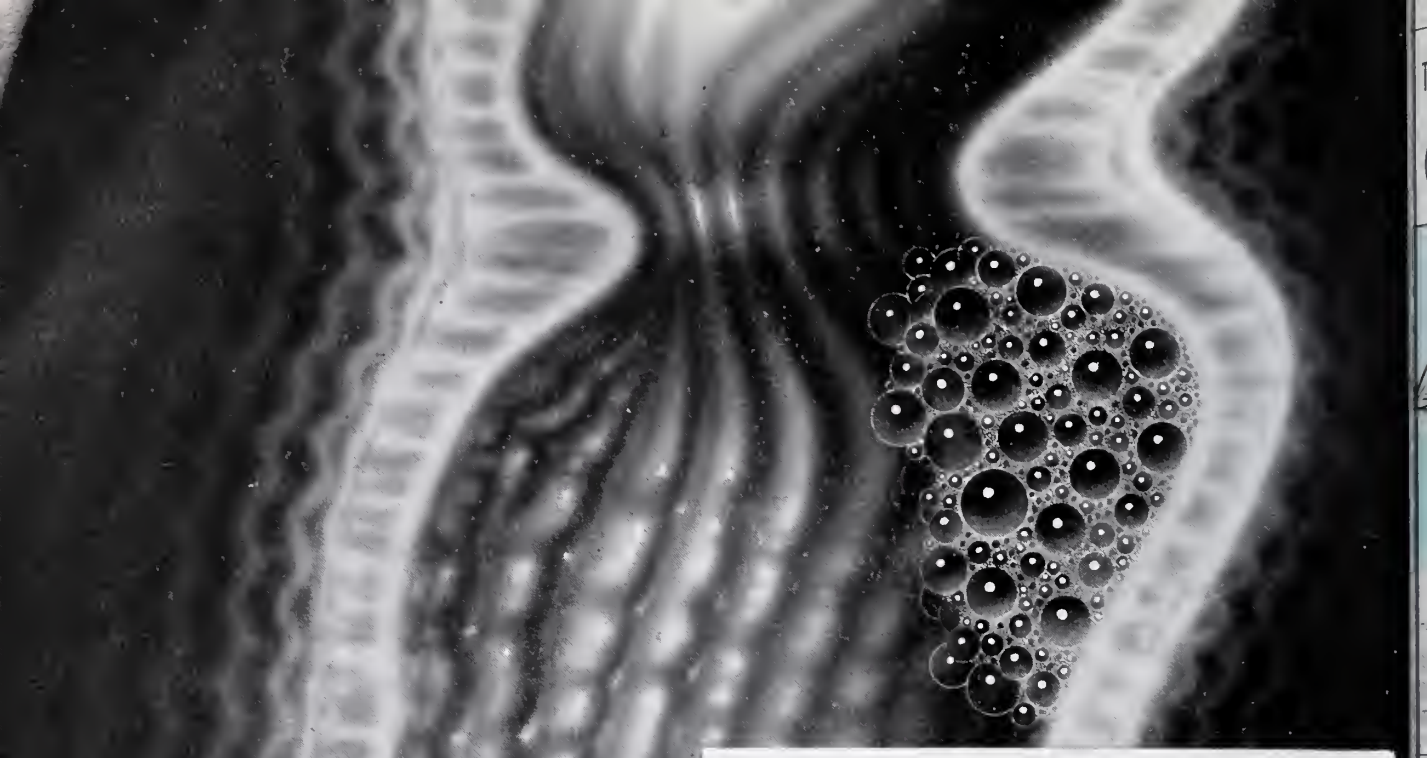
DBI-TD® Geigy
phenformin HCl

Lowers blood sugar without raising blood insulin.

...il® phenformin HCl Tablets of 25 mg.
...il-TD® phenformin HCl
...ned-Disintegration
...psules of 50 and 100 mg.

...lications: Stable, adult diabetes mellitus; sulfonyl-...ea failures, primary and secondary; adjunct to ...ulin therapy of unstable diabetes mellitus.
...ntraindications: Diabetes mellitus that can be ...gulated by diet alone; hypersensitivity to phenfor...n; renal disease with impaired renal function; a ...tory of lactic acidosis; alcoholism; juvenile dia...tes mellitus that is uncomplicated and well regu...ed on insulin; acute complications of diabetes ...llitus (metabolic acidosis, coma, infection, gan...ene); during or immediately after surgery where ...ulin is indispensable; severe hepatic disease; ...rdiovascular collapse (shock); after disease ...tes associated with hypoxemia.
...rnings: Lactic Acidosis: There have been numer...s reports of lactic acidosis in patients receiving ...enformin. This is an often fatal metabolic acido..., characterized by elevated lactate levels, an ...reased lactate-to-pyruvate ratio, and decreased ...od pH. In most cases, azotemia ranging from ...ld to severe was present. This may have been the ...sult of dehydration. In some patients who devel...ed lactic acidosis, serum creatinine was later ...thin normal limits when the patients were prop...y hydrated. Observe the following specific ...rnings:
Impairment of renal function increases the risk ...lactic acidosis. Perform renal function tests, such ...serum creatinine, prior to phenformin therapy ...d annually thereafter. Phenformin is contraindi...ted in patients with impaired renal function.
b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.
d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.
e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.
Pregnancy: Use during pregnancy is to be avoided.
Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-H (8/74)
For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502



Entrapped gas...

Silent partner of GI spasm

Painful GI spasm in the presence of entrapped gas causes even more pain and more discomfort. Yet, while spasm is relieved, entrapped gas often goes untreated.

Not so when you prescribe Sidonna. Sidonna helps release entrapped gas with specially activated simethicone, a nonsystemic antiflatulent, while also helping to relieve spasm with a traditional combination of belladonna alkaloids. And Sidonna provides mild sedation with butabarbital.

Sidonna. The therapeutic partnership approach to functional or organic GI disturbances including spastic colon, irritable bowel syndrome, gastroenteritis, gastritis, peptic ulcer and nervous indigestion.

Contraindications: hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, prostatic hypertrophy, pyloric obstruction. **Side Effects:** dry mouth, blurred vision, dysuria, skin rash, constipation or drowsiness. **Dosage:** one or two tablets preferably before meals and at bedtime.

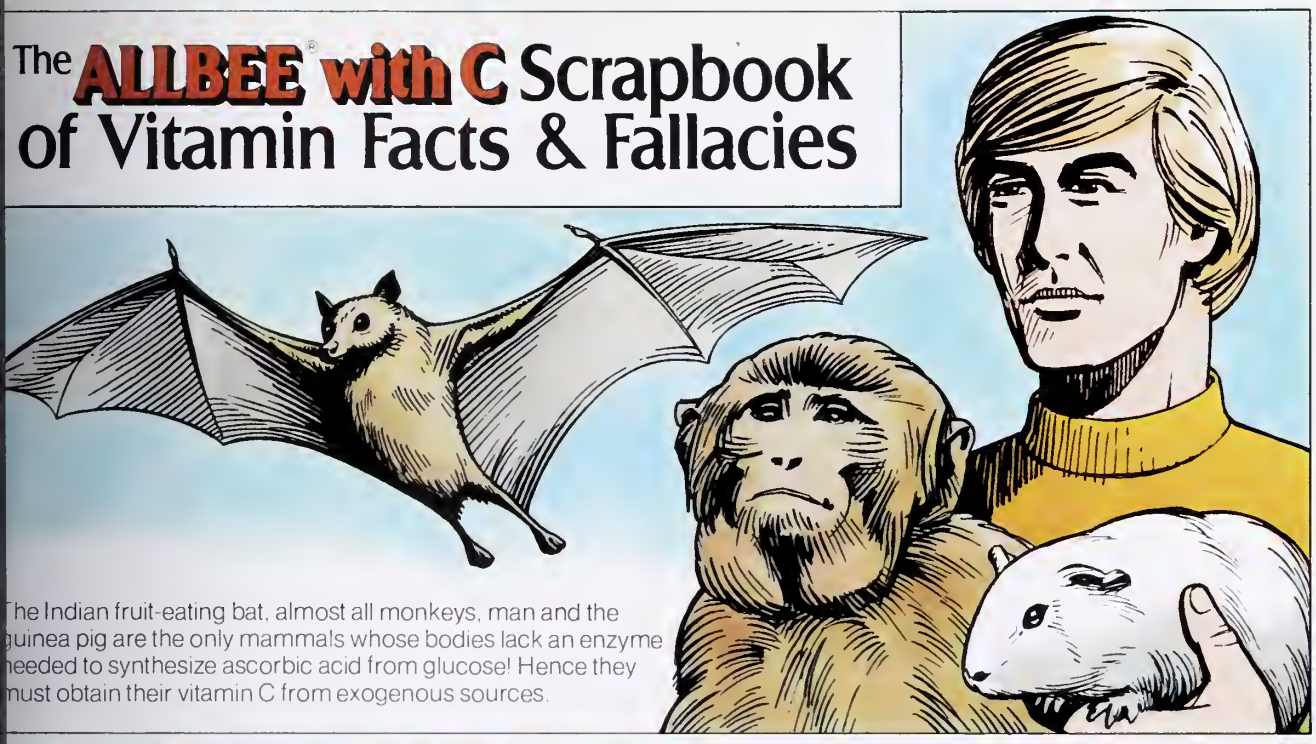
Reed & Carnrick/Kenilworth, N.J. 07033

Sidonna®

Each scored tablet contains: specially activated simethicone 25 mg., hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: may be habit forming.)

A working partnership against the pain of gas and spasm

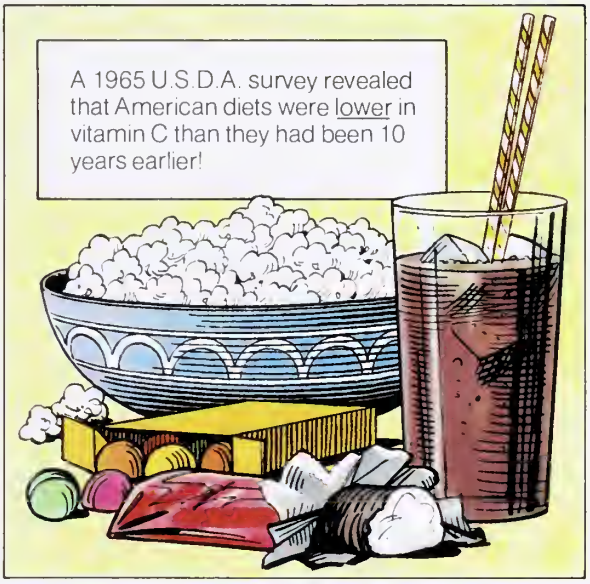
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg

Brief summary. Adverse Reactions: Blurring of vision, dry mout difficult urination, and flushing or dryness of the skin may occur higher dosage levels, rarely on usual dosage. Contraindication Glaucoma; renal or hepatic disease; obstructive uropathy (for e ample, bladder neck obstruction due to prostatic hypertrophy); hypersensitivity to any of the ingredients.

A·H·ROBINS A H Robins Company Richmond Virginia 2322

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommend
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNING section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if the dosage is indicated to effect the desired lowering of serum cholesterol.

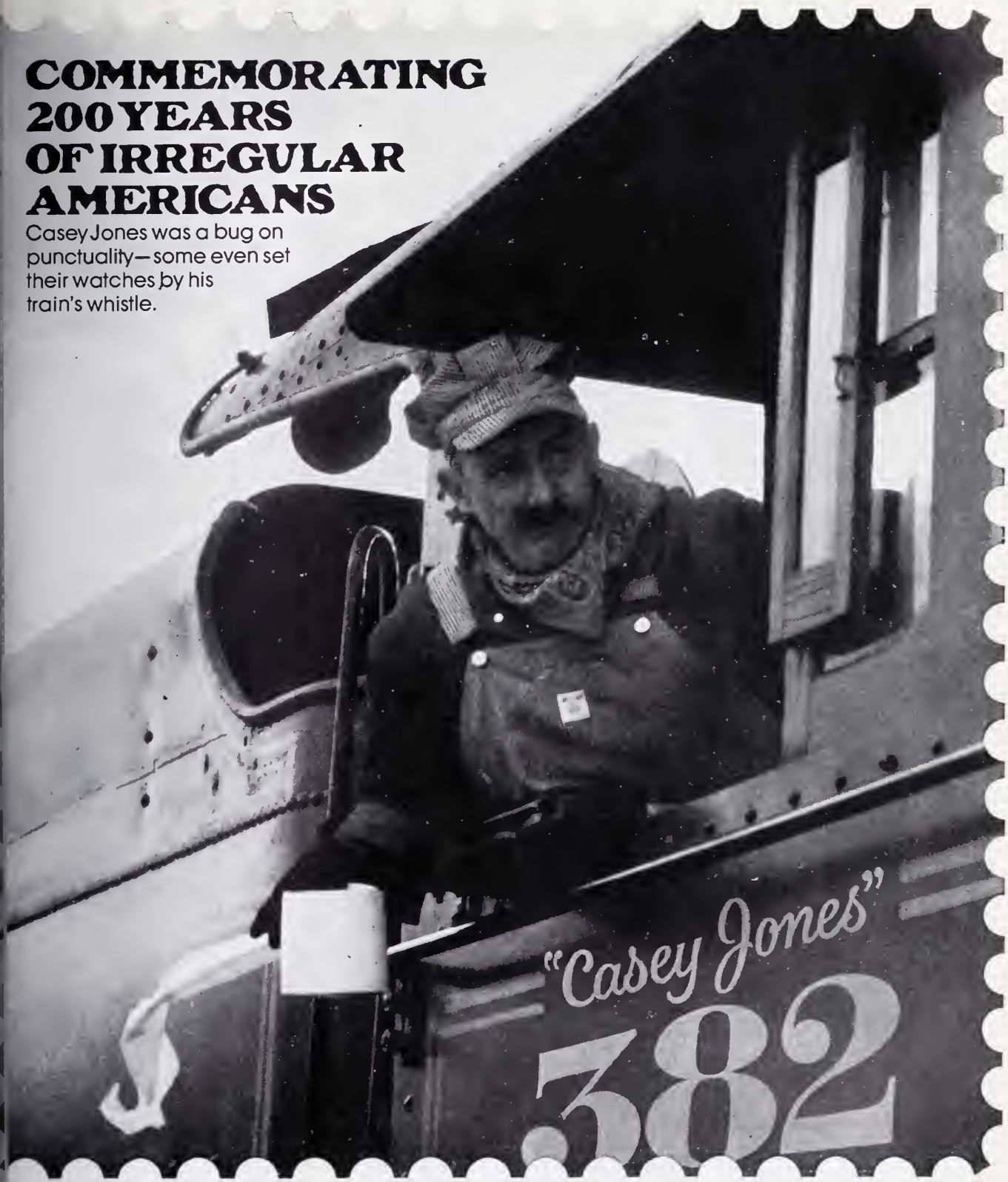
If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

COMMEMORATING 200 YEARS OF IRREGULAR AMERICANS

Casey Jones was a bug on punctuality—some even set their watches by his train's whistle.



Just get me to the station on time. For 200 years, Americans have been in a hurry. But some things just don't happen on schedule—like bowel movements in a constipated patient. And for 200 years, Americans have dealt with this problem in a variety of ways—and with varying degrees of success.

Now there's Modane.® One tablet with the evening meal provides comfortable laxation in the morning...for postoperative, pregnant, or geriatric patients. Because it's **reliable.** Because it's **predictable.** Because it's **gentle.**

MODANE®
LAXATIVE TABLETS

WARREN-TEED
PHARMACEUTICALS INCORPORATED
SUBSIDIARY OF ROHM AND HAAS COMPANY
COLUMBUS, OHIO 43215

Ortho announces
a unique,
broad-spectrum
anthelmintic
effective against
whipworm...
new
Vermox
TRADEMARK
chewable
tablets
(mebendazole)
©OPC 197

..and highly effective
against roundworm, hookworm and pinworm
n single or mixed infections

No dosage calculations — one simplified dosage, egardless of weight or age†

hipworm, roundworm, hookworm and mixed infections:
chewable tablet b.i.d. for 3 consecutive days
inworm: 1 chewable tablet

he patient is not cured three weeks after treatment, a second course of treatment is advised.

ighly effective

	Mean cure rates	Mean egg reduction
hipworm	68%	93%
undworm	98%	99.7%
ookworm	96%	99.9%
nworm	95%	— — —

mplicity of administration patients can take the tablet at any time. an be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

ot a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

onvenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

ell tolerated transient symptoms of abdominal pain and diarrhea have occurred. cases of massive infection and expulsion of worms.

ermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk ould be considered before treating these children. Vermox is contraindicated in egnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

dications Vermox* (mebendazole) is indicated for the treatment of *huris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *coris lumbricoides* (roundworm), *Ancylostoma duodenale* (common okworm), *Necator omericanus* (American hookworm) in single or xed infections.

icacy varies in function of such factors as pre-existing diarrhea and strointestinal transit time, degree of infection and helminth strains. icacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
gg reduction mean (ronge)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

ntraindications Vermox is contraindicated in pregnant women e: Pregnancy Precautions) and in persons who have shown hyper- nsitivity to the drug.

*TRADEMARK

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.
Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.
Dosage and administration The same dosage schedule applies to children and adults.
For control of trichuriasis, ascariasis, and hookworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.
If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.
How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

Ortho Pharmaceutical Corporation,
Raritan, New Jersey 08869

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One contains aspirin.
One doesn't.

Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MAY, 1975 • VOLUME 62 • NUMBER 5

The EMI Scan

ROGER G. SCHNELL, M.D.; WILLIS N. DICKENS, M.D., AND JAMES B. PERRY, M.D.

Abstract: The EMI Scan utilizes computerized axial tomography, a revolutionary technique, that measures the transmission of x-ray photons across a particular layer of brain, and then by computer, constructs a pictorial array of intracranial structures which is displayed on an oscilloscope.

Pathologic entities are diagnosed by alteration in tissue density as well as distorton of normal anatomical structures. Cerebral edema, cysts, cerebral infarction, or brain tumors may present as decreased densities, whereas intracerebral hematomas and some tumors demonstrate increased tissue density.

Thus, the unique ability of the EMI Scan to clearly define the internal anatomy of the cranium by means of a noninvasive painless technique has dramatically revolutionized the field of neurodiagnosis.

The EMI-Scanner is a unique neurodiagnostic machine developed by Godfrey N. Hounsfield at EMI Laboratories, Middlesex, England from 1967 through 1972. The revolutionary EMI's Computer Assisted Tomography (CAT) was first used in this country at the Mayo Clinic in June 1973. The equipment measures the transmission of x-ray photons across a given transverse layer of the brain; then by computer constructs a picture display on an oscilloscope tube and provides numerical absorption units as printout. This noninvasive technique has altered the practice of neurology and neurosurgery, and facilitated the diagnosis of intracranial disease.

The examination is carried out with the patient lying on an hydraulically adjustable table. The head is inserted into a snugly fitting rubber cap which projects into a water filled compartment. With a grease pencil a baseline 20° inferior to the orbitomeatal line is made on the side of the patient's face; thus permitting the head to be accurately positioned with respect to the x-ray beam. This angulation allows the posterior fossa to be viewed in respect to brain structures.

The scanning utilizes a narrow x-ray beam passing through the head and detected by two sensing devices aligned with the x-ray source on the direct opposite side of the skull. This x-ray gantry rotates 180° around the head making 180 separate 1° scanning views. Each scan evaluates two horizontal contiguous slices of brain each 1.3 cm. (or 8 mm.) thick on either side of a plane to which the x-ray beam is aligned and takes about four minutes time. At the end of each scan the head is moved 2.5 cm. from the baseline. This is repeated up to four times producing eight slices portraying brain tissue from the lowest level of the external auditory canal to the vertex parasagittal region.

The information from each slice consisting of 28,000 simultaneous equations is fed into a computer and the results by algorithmic technique are transformed into absorbtion coefficients and relative densities of individual data points. This information is reconstructed in the form of an 80 by 80 cell matrix with each cell measuring 2.9 x 2.9 x 1.3 mm. (0.8 cm). An absorption value is calculated for each cell and is available as a numerical printout in the general shape of the skull, or as picture points on an oscilloscope which can

be photographed. Current equipment utilizes a 160 x 160 matrix and gives finer visual imagery within 30 seconds of computer processing.

An arbitrary scale of absorptive values from air at -500 displayed as black to compact bone at +500 displayed as white has been adopted. Water has a value of 0 and most intracranial soft tissue structures vary from 0 to 20. Thus, different tissues are depicted as shades of grey which lighten with increasing density. Approximate values on this scale include: cerebral cortex +18, white matter +14, cerebrospinal fluid and ventricular fluid +1, fat -50, blood +7, clotted blood +28, and calcium +20 to +200, depending on density.

The pictorial display is examined in a methodical fashion with normal anatomical features identified, such as the bony structures of the skull, grey and white matter, (including the basal ganglia), ventricular system and cisterns, Sylvian and interhemispheric fissures, cerebral sulci, calcified pineal and choroid plexuses. Changes in tissue density as well as alteration in size and shape, and distortion and displacement of the anatomical structures are considered. Abnormal substances such as blood, foreign bodies, tumor and pus are searched for.

Abnormal Scan

The abnormal scan portrays absorptive values that are high, low or normal. Low values or low tissue densities are produced by pathologic processes that destroy cellular structure and increase fluid content. Specific examples include cerebral infarction, infection, neoplasm, cerebrocranial trauma and edema.

In cerebral infarction one can frequently identify the lesion by involvement of both grey and white matter in a known pattern as with "wedge shape" in the middle cerebral arteries, internal capsular, and the absence of other features such as ventricular shift frequently associated with mass lesions. The changes may be seen as early as 12 hours but clear delineation of the boundaries of the infarction may not be manifest for 7-14 days. (Fig. 1.) In older lesions the ventricle may be seen as enlarged on the side of the infarct and shifted toward it.

Brain tumors most frequently present as a decrease in density due to cell destruction and surrounding edema. A tumor nodule may show as increased density with a zone of decreased density. This feature associated with the mass

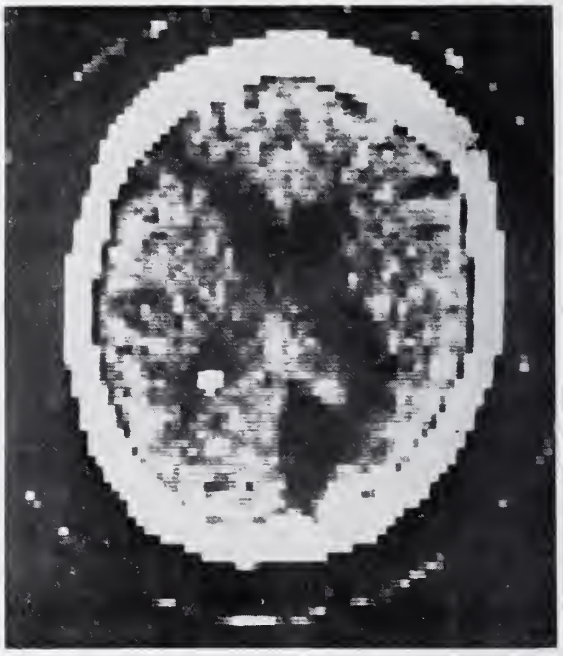

Fig. 1. Infarction. Occlusion of right posterior cerebral artery occurring 14 days before scan, showing well demarcated border involving white and grey matter in occipital lobe. There is a smaller, one-year-old, left frontal lobe infarct.

affect of a space occupying lesion allows specific identification. Similar changes may be produced by an abscess, but specific clinical data helps differentiate the etiology. The presence of two lesions with these characteristics would suggest metastatic etiology (Figs. 2A & 2B). Some tumors present as increase of density such as meningiomas (but may be low density) or calcified tumors (Fig. 3). Cerebrocranial trauma also produces significant tissue edema and can be identified by the low absorptive values.

Subdural hematoma presents as varying tissue densities depending upon the stage of the pathologic process. In the acute phase it often presents as a decreased density surrounding peripheral brain as a crescent. As consistency increases the density may become similar to surrounding brain and identification is determined primarily by its mass effect, as Ambrose describes, "unbroken apparently normal brain density." High density units of the subdural are thought to arise from deposition and concentration of calcium, and iron and organization of the fibrous tissue (Fig. 4). Epidural hematomas usually present without diagnostic difficulty.

Primary intracerebral hemorrhage presents as high absorptive values. Clotted blood (+22 to +35) has a greater density than normal brain.

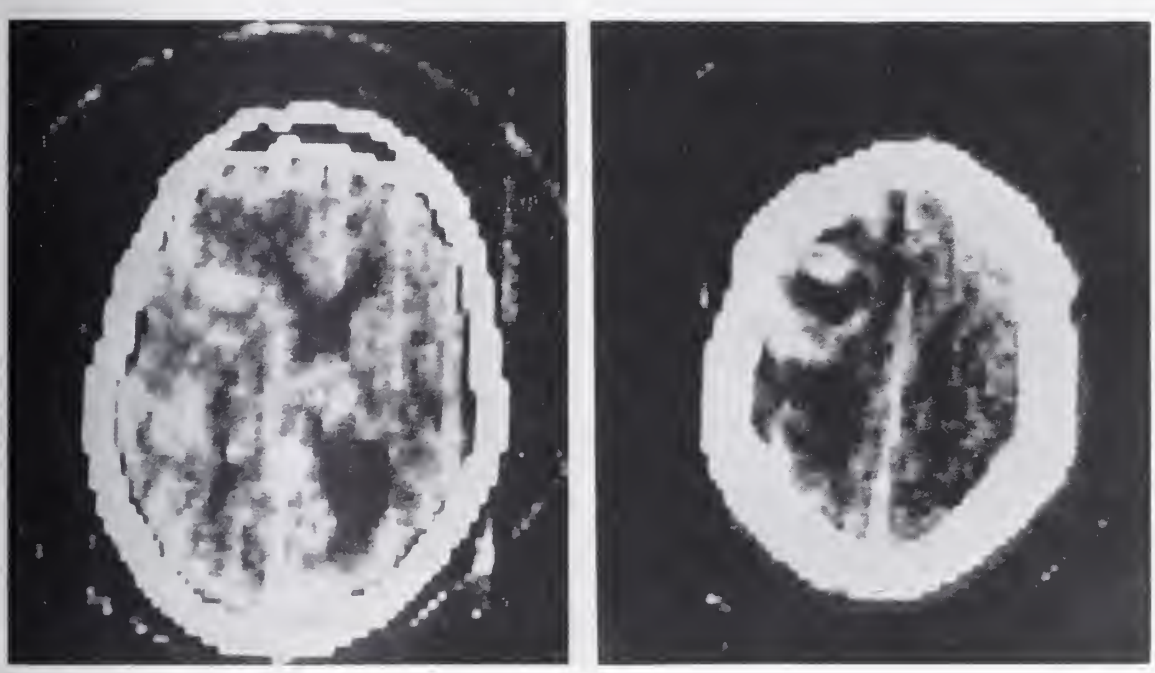

Fig. 2. A. Metastatic lesions from carcinoma of lung. A large irregular increased density, surrounded by decreased density representing edema, is seen in the left frontal region. A second tumor nodule can be visualized in the left parietal lobe. The lesions have distorted and shifted the anterior ventricular horns and obliterated the body of the left lateral ventricle. B. On the 6B slice the frontal nodule has extended superiorly to the vertex and demonstrates a central area of decreased density representing a necrotic center.

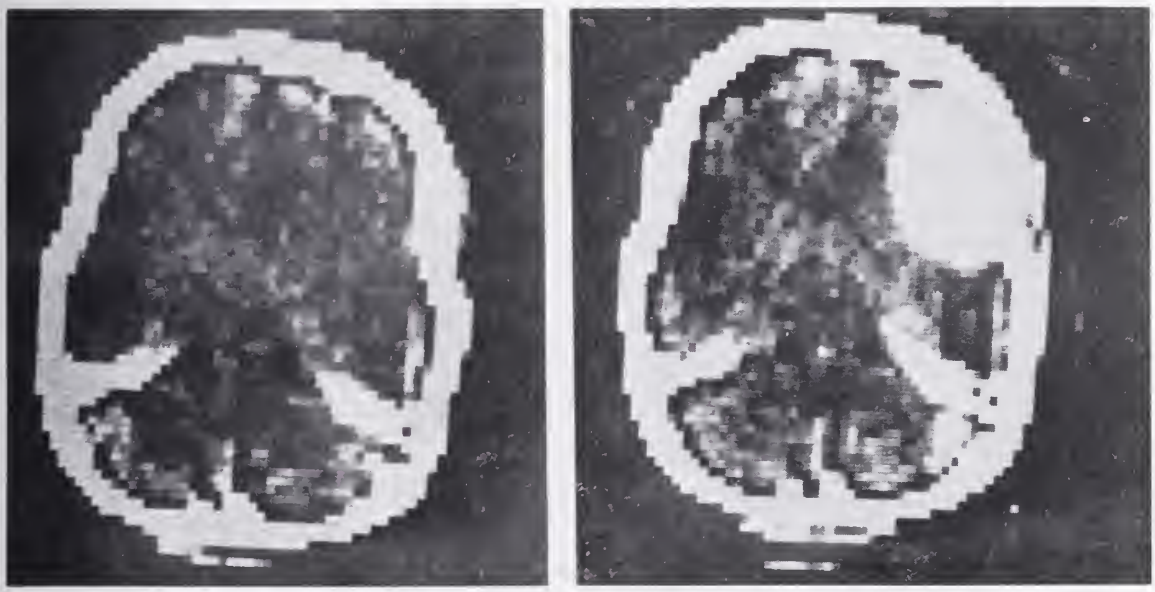

Fig. 3. A. Right pterion meningioma. On plain scan, the 1B slice shows minimal increase density near the periphery of the right frontal lobe and the boney tissue is widened. B. With 50 cc. intravenous Conray-400, rescan showed marked enhancement of the vascular tumor mass.

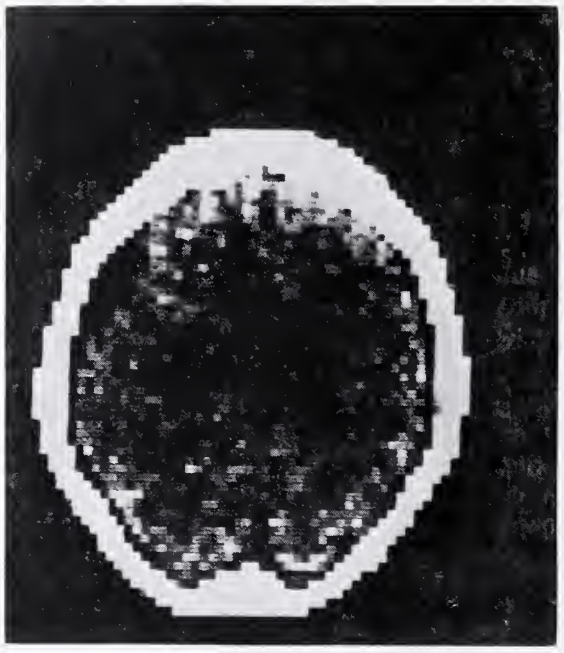

Fig. 4. Subdural hematoma. A low density crescent can be seen capping the left temporoparietal lobes.

The hematoma thus appears as a lightened circumscribed abnormality clearly delineated in its size, relationship to internal structures and closest point to the brain surface. In addition the extent of surrounding edema can be evaluated. This

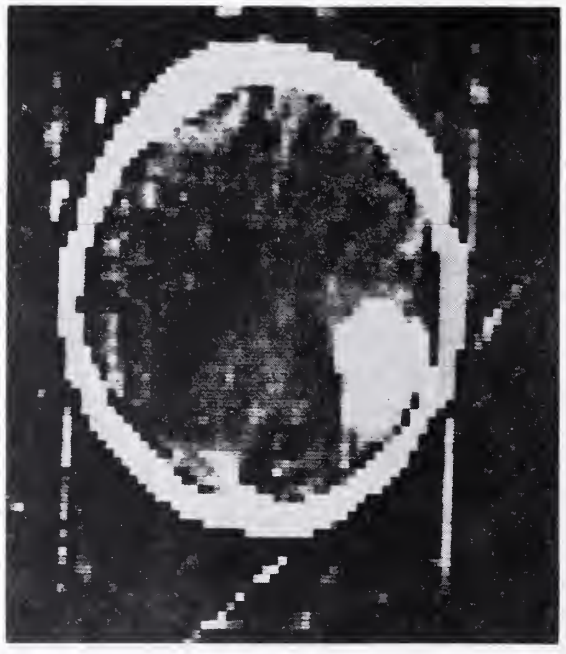

Fig. 5. Primary intracerebral hematoma. A large right-sided temporoparietal density representing an intracerebral hematoma. The area of density abuts inner table of the skull demonstrating to the neurosurgeon where he could enter the brain to evacuate the hematoma without injuring normal tissue.

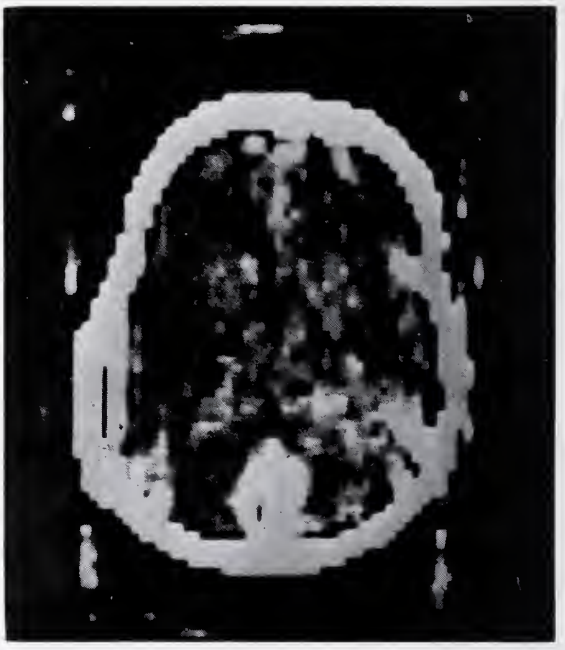

Fig. 6. Cerebellar hematoma. A large circumscribed density located in the cerebellar vermis in a hypertensive patient. Angiograms indicated arteriovenous malformation as the cause.

information provides a "new prospective hitherto unavailable" to the neurosurgeon and neurologist (Figs. 5 & 6).

Although ruptured aneurysms cannot be identified with the EMI-Scan, the presence of small localized hematomas, local cerebral edema, or clotted blood in specific cerebral fissures is valuable information identifying or confirming which aneurysm may have ruptured. Blood in the Sylvian fissure is most likely due to a ruptured middle cerebral or internal carotid artery aneurysm.

There is a group of lesions whose absorptive values are near that of normal brain tissue and therefore difficult to identify. These lesions if small and peripheral in location may not distort the ventricular system. However, one can artificially raise the absorptive values of abnormal tissue by injection of intravenous iodine containing compounds such as Hypaque® or Conray®. Tissues with increased vascularity will have greater photon absorption and thus enhance visualization. Tumors that have a large vascular supply such as meningiomas (Fig. 3) and metastatic neoplasms show up as dense areas. This method is helpful in evaluating tumors demonstrating decreased absorptive values. The tumor nidus, following contrast enhancement, can frequently

be delineated from the surrounding cerebral edema.

The EMI-Scan clearly defines the internal anatomy of the cranium. The ventricular system is routinely evaluated, and enlargement of the anterior horns, bodies, and posterior horns, third ventricle, and presence of widened Sylvian fissues, interhemispheric fissure and cerebral sulci are diagnostic of cerebral cortical atrophy. The temporal horns are seldom displayed. Likewise, the presence of a dilated ventricular system with normal cerebral cortex should raise the possibility of occult hydrocephalus. Anatomic details of low or normal pressure hydrocephalus may be demonstrated but to date no pathognomonic features are reported. A dilated ventricular system with a normal-sized third and fourth ventricle suggests the diagnosis of obstructive lesions at the level of the foramen of Monroe. Other lesions clearly visualized have been true and pseudo-porencephalic cysts and anencephaly.

Discussion

Our initial experience has demonstrated the EMI-Scan to be a brief, painless, valuable, noninvasive neurodiagnostic procedure. We have utilized it in over 2,000 patients in a ten-month interval. Frequently the test provided sufficient information in respect to location, distortion of structures, tissue abnormality, and possible nature of the lesion that treatment could be instituted without the need of additional tests. Arteriograms were not necessary for the diagnosis of hypertensive intracerebral and cerebellar hemorrhage. Contrast studies were no longer used as an exploratory method in suspected hydrocephalus. The patient with dementia or suspected degenerative central nervous system disease could be studied without the deleterious effects of the pneumoencephalogram. In some cases of head trauma the EMI-Scan provided all the information needed for management and surgical treatment of the patient. In the epileptic of late onset, the evaluation of possible neoplasm allowed us to manage the patient on a more informed basis. The presence of two intracerebral lesions in the patient with a primary carcinoma quickly directed the appropriate therapeutic course. The postoperative course of the brain tumor patient can be expeditiously monitored with the EMI-Scan. Furthermore, the scan allows the rapid assessment of ventricular shunt function.

By eliminating the morbidity and mortality associated with pneumoencephalograms and arteriograms, the EMI-Scan has proven applicable to a larger number of patients at an earlier stage in the disease process. Furthermore, we have used the test as an outpatient screening procedure to rule out significant intracranial pathology in the patient with headache, dizziness, and other common neurologic complaints.

In a few areas the use of the EMI-Scan is limited. Small structures and lesions such as chiasmatic and/or optic nerve tumors, or small tumors in the cerebellopontine angles were poorly delineated. Arteriograms still remain the only effective method for displaying specific blood vessel abnormalities such as aneurysm, angioma and obstructive disease. However, in the overall study of cerebrovascular disease the EMI-Scan has been invaluable in distinguishing between bland infarction and hemorrhage. It has been our initial impression, confirmed by the wider experience of others, that the EMI-Scan is revolutionizing the field of neurodiagnosis and consequently the practice of neurology and neurosurgery.

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If the trumpet gives an uncertain sound, who shall prepare himself for battle?

(Submitted to The Journal by Robert J. Needles, M.D., St. Petersburg).

Management of Injuries to Inferior Vena Cava

Sibu P. Saha, M.D.; R. Daley Goff, M.D., and Sam E. Stephenson Jr., M.D.

Abstract: Survival after injuries to the inferior vena cava has improved in recent years. Major contributing factors have been increased awareness of the techniques and principles of vascular surgery and experience in management of these injuries. Case histories of 16 patients with injuries to the inferior vena cava have been reviewed. Four patients died from this injury, yielding a mortality of 25%. This report emphasizes certain practical points in the management of this potentially lethal injury.

During the five year period 1967 through 1972, 16 patients were treated for injuries of the inferior vena cava at University Hospital and St. Vincent's Medical Center in Jacksonville. With the exception of one patient, who was six years old, ages ranged from 17 to 44 years. Eleven were men and five were women. The injuries were caused by gunshot wound in 14 and blunt trauma in two (Table 1).

The locations of the vena caval injuries are shown on Table 2. The injuries to the inferior vena cava were divided into suprarenal (suprahepatic, retrohepatic and infrahepatic), renal and infrarenal groups. There were three deaths in the infrarenal group and one in the suprarenal group. The causes of death are shown on Table 3.

In this series, every vena caval wound was associated with at least one additional injury (Table 4). Two patients had associated aortic injury and died of renal failure. There were 52 major associated injuries in 16 cases.

All patients showed signs of intra-abdominal injury at the time of admission and the need for surgical intervention was obvious. Preoperative evaluation revealed hypotension in ten patients. All deaths occurred among the hypotensive patients, and massive blood loss was found in all. There were eight major complications in 12 survivors (Table 5). Most complications were related to associated injuries of the gastrointestinal tract. The average duration of hospitalization for the 12 survivors was 18 days with a range of eight to 39 days.

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Treatment

During preoperative evaluation and preparation the vital signs are carefully monitored. Routes are established for the rapid administration of large volumes of intravenous fluid. A catheter is placed in the superior vena cava, using one of the popular percutaneous techniques, for monitoring central venous pressure and also for rapid administration of intravenous fluid. Simultaneously a sample of blood for type and crossmatch and a urine specimen are submitted to emergency laboratory for analysis. The in-dwelling Foley catheter affords a reliable adjunct in monitoring the resuscitation and volume replacement. A nasogastric tube is inserted to empty the stomach. Most of the patients were intoxicated at the time of admission. When the patient has not been in shock or becomes quickly stabilized with minimal fluid replacement, chest and abdominal x-rays and intravenous pyelogram are done in the emergency room. However, if shock is nonresponsive to blood replacement, a laparotomy is performed immediately to control further blood loss. In urgent situations O-negative blood is used pending completion of the standard crossmatch. Blood pressure, urine output, CVP and EKG are carefully monitored while surgical mission is accomplished. When a patient is transfused with more than ten units of whole blood, a unit of fresh blood is given. Blood is also drawn

Table 1.—Mechanism of Injury Related to Survival.

TYPE INJURY	NUMBER PATIENTS	ALIVE	DEAD
Blunt Trauma	2	2	0
Gunshot Wound	14	10	4

Table 2.—Mortality According to Level of Injury.

LOCATION	NUMBER PATIENTS	MORTALITY
Suprarenal	5	1
Renal	1	0
Infrarenal	10	3
Total	16	4 (25%)

Table 3.—Causes of Death in Four Patients With Vena Caval Injuries.

CASE	SITE	ASSOCIATED INJURIES	CAUSE OF DEATH
1	Infrarenal	Aorta and colon	Septicemia and stress Ulcer
2	Infrarenal	Aorta and colon	Renal failure
3	Infrarenal	Stomach, small intestine, pancreas and iliac veins	Renal failure
4	Suprarenal	Colon, gallbladder, liver, portal vein and hepatic Vein	Exsanguination

for serum electrolytes, calcium and blood gas analysis for necessary correction of acid-base imbalance.

The objective of operation is initially to prevent blood loss and finally to repair the damaged tissues. Hemostasis first is obtained by application of direct pressure. All retroperitoneal hematomas should be explored;[1] however, adequate preparation should be taken before exploration. For a hematoma at or below the level of transverse mesocolon, exposure is obtained either by evisceration to the right followed by incision in the left leaf of the small bowel mesentery at its base or by evisceration to the left followed by reflection of the right colon to the left. The approach, consisting of mobilization of the hepatic flexure and transverse colon inferiorly, combined with Kocher maneuver is best for injuries above the level of the transverse colon. Injuries to the retrohepatic vena cava present difficult technical problems. In one case with a similar problem, we extended our incision into the right hemothorax and used an intracaval shunt and repaired the vena caval injury successfully (Fig. 1). The intracaval shunt provided us a bloodless field with minimal impairment of venous return. We were also able to rotate the liver quite easily without noticeable cardiovascular effects. This shunt is also useful in performing hepatic resection. In one case, during right hepatic resection for a stellate laceration, we found an associated vena caval injury (Fig. 2). In this series, vascular clamps were used to obtain proximal and distal control, and vena caval wounds were closed by direct suture.

Table 4.—Major Associated Injuries.

Bowel (stomach 8, duodenum 6, jejunum 5, colon 3)	22
Liver	5
Pancreas	5
Spleen	1
Adrenal	1
Other Vessels (aorta 2, renal vein 1)	10
Miscellaneous	8
TOTAL	52

Comment

Wounds of the inferior vena cava are infrequent but carry a high mortality because of massive blood loss and associated injuries. Only within recent years has there been progressive improvement in survival rates because of increased experience in the management of critically ill patients in general and vascular injuries in particular. Of our group 12 survived, yielding a mortality of 25%. The most important single factor influencing their survival appeared to be the amount of blood loss. Weichert and Hewitt[2] reported that blood loss and the number of organs injured were excellent prognostic aids as to the eventual morbidity and mortality in their series.

A systematic approach to the patient with suspected intra-abdominal vascular injury is of paramount importance. During preoperative preparation the most important therapeutic measure is adequate replacement of whole blood. Operation is an integral and necessary part of resuscitation. Hemostasis should be obtained initially by direct pressure. The vena cava should then be exposed using one of the approaches recommended by Starzl et al.[3] If the wound is tangential or involves only the anterior wall without significant loss of tissue, hemostasis may be secured by applying a partial occulsion clamp. The defect can then be repaired using fine cardio-

Table 5.—Postoperative Complications Among 12 Survivors of Inferior Vena Cava Injuries.

COMPLICATION	INCIDENCE
Renal failure	2
Fecal fistula	1
Biliary fistula	1
Wound dehiscence	1
Septicemia	1
Gastrointestinal bleeding	1
Suture leak	1
Subphrenic abscess	1
Total	8

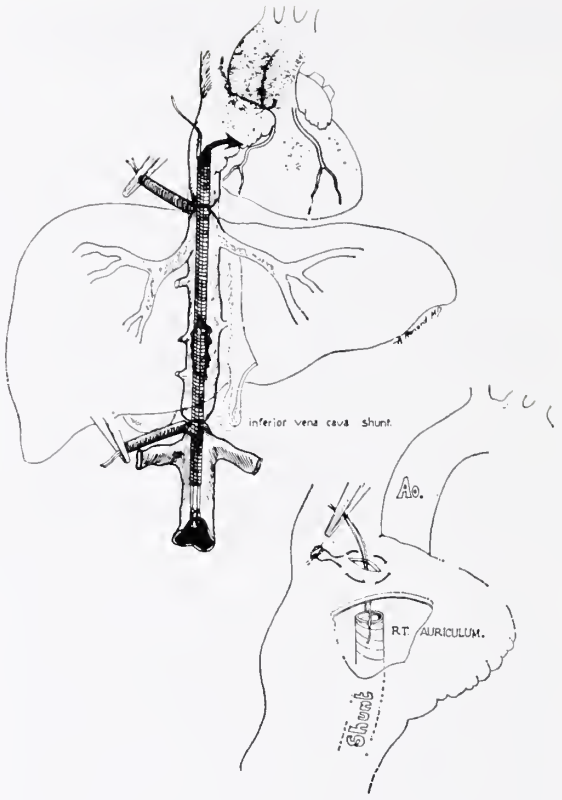

Fig. 1.—Sewing intracaval shunt into place.

vascular sutures. In case of a through-and-through injury, the posterior wall may be repaired through the anterior defect or by rotating the injured segment of the inferior vena cava. This type of injury requires proximal and distal control of the vessel before repair.

Oschner et al[4] stated that there is no real advantage to repair over ligation when the injury is below the renal vein. Smith et al reported one patient out of seven died after repair of the infrarenal vena cava whereas seven of 15 died after acute ligation.[5] Ligation of the infrarenal vena cava is justified if tissue loss prevents primary repair. Injuries at or above the renal vein should be repaired although patients have survived suprarenal vena caval ligation.[6,7] Retrohepatic vena caval injuries present difficult technical problems. The use of an internal vascular shunt, as suggested by Schrock et al,[8] permits repair to be accomplished in a bloodless field with minimal impairment of venous return. Duke et al[9] suggested use of a saphenous vein patch graft or infrarenal segment of cava for reconstruction of loss of substance wounds of the suprarenal

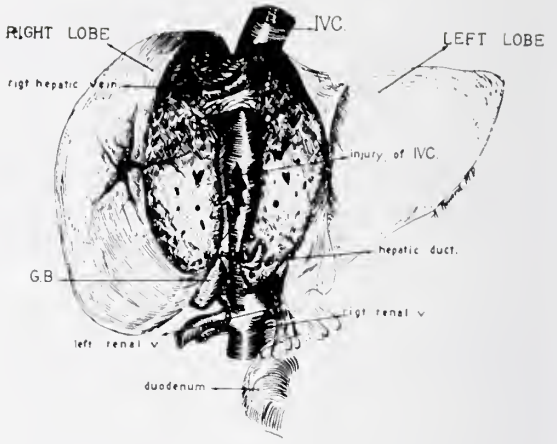

Fig. 2.—Shows the stellate factor of the right lobe of liver and injuries of the retrohepatic inferior vena cava.

segment. Soyer et al have used a new venous prosthesis in experimental animals which hold promise for the future.[10]

Summary

Case histories of 16 patients with injuries to the inferior vena cava have been reviewed. The management of this potentially lethal injury has been discussed with review of recent literature. This report affirms the serious consequences of this injury but indicates that an appreciable salvage rate is possible.

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Incidence of Positive Streptococcal Culture in Patients With Sore Throat

S. K. Nayer, M.D., and Margaret W. Linn, M.S.S.W.

Abstract: Results from 227 throat cultures showed no relationship between the clinical decision to treat the patient and the presence of streptococcus. About 38% of the patients were treated on a clinical basis and slightly over a fourth of these were found to have had a positive culture. Likewise, for the 62% who were not treated on a clinical basis, 20% had had positive cultures. Findings suggest that one can not tell the difference on clinical examination whether it is beta streptococcal infection or not.

One important reason for a culture in the patient with sore throat is to rule out the presence of beta hemolytic streptococcus. The finding of antecedent Group A sites should serve to isolate the organism and help institute appropriate therapy to prevent occurrence of rheumatic fever and glomerulonephritis. Probably the most common site of infection is the upper respiratory tract. Most URIs are viral in etiology, as has been documented in the Cleveland family study.[1] Streptococcal infections, while common, lead to rheumatic fever only in a small percentage of cases. In contrast to the high incidence observed in epidemics of streptococcal pharyngitis, is the much lower rate following endemic or sporadic streptococcal upper respiratory infections.

The natural history of Group A streptococcal infections appears to have undergone a change during recent decades. Evidence indicates that their clinical severity may have waned in comparison with former years when extensive epidemics, including those associated with scarlet fever, occurred and when suppurative complications and erysipelas were frequently seen. Puerperal sepsis and septicemia of the newborn associated with the infection are reported far less often now. Although there has been a significant decline in suppurative sequelae, rheumatic fever and glomerulonephritis remain a serious problem and represent a continuing challenge.[2]

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Epidemiologically streptococcal pharyngitis has certain salient features. It is most common in children, ages 6-9. Generally, streptococcal respiratory infection occurs with more frequency over a more prolonged period of time in temperate and colder climates. Epidemic pharyngitis has been a problem in institutions and among young adults at military recruit training bases. Multiple cases of streptococcal infection of the respiratory tract commonly occur in families but confirmation is often difficult because of asymptomatic cases. Acute streptococcal pharyngitis is a true "chance" infection, i.e., an infection that commonly occurs in an otherwise healthy host without the necessity of predisposing illness or injury. The transmission of streptococcal infection of the upper respiratory tract results from direct contact. The likely mechanism is large droplets. Patients with acute pharyngitis are clearly contagious and the nasal carrier, shedding large numbers of streptococci, is considered especially dangerous.

Clinically, the signs and symptoms of streptococcal pharyngitis are sore throat, pain on swallowing, fever, headache, malaise, abdominal complaints, redness and edema of the pharynx, exudate, cervical lymphadenitis, petechial lesions of palate and uvula, and exanthem of scarlet fever. However, adenovirus, C. diphtheriae, may also produce similar signs and symptoms.[2]

Previous studies of the incidence of streptococcal infection in Miami have been carried out by Saslaw and coworkers[3-4] in which frequent presence was reported in the throats of children. The incidence of rheumatic fever and rheumatic heart disease was low, however; and the rise in ASO titer not as high as observed in the north. Stollerman[5] has suggested that streptococcal disease in Miami may be less potent antigenically and therefore causes a lower incidence of rheumatic fever.

With this knowledge, it seemed that very little relationship would exist between clinical findings and presence of streptococcus. Indeed, it is well recognized that rheumatic fever may also follow mild or inapparent streptococcal infections.

The purpose of this study was to determine if patients treated clinically for sore throats also had more positive cultures for streptococcus.

Method

Data were collected from November 1972 to March 1973 in the Primary Care Unit (PCU) at Jackson Memorial Hospital in Miami. The Unit was one of the service-teaching ambulatory facilities of the Department of Family Medicine of the University of Miami School of Medicine. All patients coming to PCU who had sore throats had a culture taken. Prior to initiation of the study, residents had established a protocol requiring throat cultures for the management of sore throat.

After examination, cultures were obtained by swabbing the pharyngotonsillar area, streaking it on a blood agar plate and incubating in the standard manner. These plates were then labeled with enough information to contact patients if necessary.

The criteria for clinical treatment were: (a) the general condition of the patient in that he appeared to be toxic, (b) temperature over 100 F., (c) pharyngotonsillar area congested with exudate, (d) associated peritonsillar abscess, cellulitis, otitis media, bronchitis, laryngotracheobronchitis, pneumonia, cervical lymphadenopathy, or (e) history of rheumatic heart disease.

Patients were instructed on the reason for the throat culture, in the care of soreness of the throat, and advised to call for results the next day. In the event of positive culture, they were treated with benzathine penicillin or erythromycin if allergic to penicillin.

Criteria for positive cultures were essentially clear hemolysis with a sufficient growth of bacteria and morphology of the colony. No bacitracin discs or selective media for Group A streptococcus were used.

Results

A total of 227 throat cultures were done and about a fourth were read as positive. Table 1 shows that 86 persons (38%) were treated with antibiotics on a clinical basis. Twenty-eight percent of them had positive cultures as compared with 20% in the group not treated clinically. The relationship was not found to be significant statistically.

Table 2 shows age in relationship to treatment and positive findings. Age ranged from seven to 78 years, with 84% of the cultures being done in the 11-40 age group. Among those patients

Table 1.—Relationship of the Decision to Treat A Patient Clinically to the Occurrence of Positive or Negative Culture.

	CULTURE				TOTALS	
	Positive		Negative			
CONDITIONS	#	%	#	%	#	%
TREATED	24	28	62	72	86	38
NOT TREATED	28	20	113	80	141	62
TOTALS	52	23	175	77	227	100

treated on a clinical basis, more positive cultures were identified in the 11-20 age group. Among those not treated, more positive cultures were found in the 31-40 year group, indicating a slight tendency toward false negatives in older patients.

About 23% of the 74 males were found to have positive throat cultures and 23% of the 153 females. Males tended to be treated a little more often than females, 45% as opposed to 35%, and as a result slightly more of them were found to have positive cultures.

The majority of positive findings occurred for tonsillitis and pharyngotonsillitis, essentially about the same percentage for each diagnosis whether the patient had been treated clinically or not.

Discussion

This study found 23% positive cultures which probably represent the true incidence of beta hemolytic streptococcus in symptomatic patients. Some studies have shown higher rates when multiple cultures were taken. There may also have been a general tendency to overread positive cultures, particularly by some residents.

The results showed no relationship between the clinical decision to treat patients and the presence of streptococcus. Of the 38% treated on a clinical basis 28% had positive throat cultures, i.e., had correct clinical diagnosis, and the remaining 72% had incorrect clinical diagnosis and were possibly unnecessarily medicated. Of the 62% who were not treated on a clinical basis, 20% had positive cultures, i.e., had incorrect clinical diagnosis or in whom medication was indicated.

Studies elsewhere have suggested the need to review the entire traditional approach of penicillin for the management of this common illness.

It is difficult to differentiate symptomatic patients from asymptomatic carriers[6] because of the presence of Group A streptococcus in throats of asymptomatic persons and rise of streptococcal antibodies in these individuals.[7] Again, in a sig-

Table 2.—Relationship to Treatment and Findings of Positive Cultures.

VARIABLES	GROUPS			
	TREATED CLINICALLY		NOT TREATED CLINICALLY	
	# Treated	% Positive	# Not Treated	% Positive
AGE				
0 - 10	1	0	2	0
11 - 20	25	36	48	15
21 - 30	36	28	49	18
31 - 40	15	27	18	33
41 - 50	4	0	15	20
51 - 60	1	0	6	17
61 - 70	4	25	2	0
71 - 80	0	0	1	2
SEX				
Male	33	30	41	17
Female	53	26	100	21
CLINICAL DIAGNOSIS				
Pharyngitis	26	27	52	21
URI	9	11	51	18
Tonsillitis	22	41	12	50
Pharyngotonsillitis	8	38	6	50
B Strep Throat	6	0	0	0
Flu	2	50	3	0
Screening B Strep in Family Contacts	0	0	5	0
Sore Throat	0	0	4	25
URI with OM	4	25	0	0
Tonsillitis with Abscess	4	25	0	0
Common Cold	0	0	2	0
All Other	5	20	6	0

nificant number of patients with acute sore throat treated by traditional methods,[8] the recovery of hemolytic streptococcus is not possible. However, when these hemolytic streptococci have been isolated, they have been identified as belonging to Group A.[9]

Throat culture of infected patients showed presence of hemolytic streptococcus in only two thirds of these patients. The use of oral penicillin has limited efficacy, since 25% of patients treated with it had streptococcus in their throats on the fifth day after treatment.[10]

Implications

Our findings showed that one could not determine on clinical examination whether it is beta streptococcal infection or not. In light of this, physicians ought critically to review their practice. There appears to be little justification for the use of antibiotics on the basis of clinical suspicion of streptococcal infection. Penicillin and other antibiotics are considered by the lay person as a panacea for fevers, sore throats, and colds and has in turn created an unnecessary demand on the medical care system. The physician ends up treating mild, self-limited illnesses as if these conditions were serious. He becomes disease and diagnosis obsessed and often overlooks the fundamental problem that brought the patient to him in the first place.

In doing a throat culture, which at present seems to be the only practical and acceptable method of establishing the diagnosis of streptococcal pharyngitis, the physician treats on a scientific basis giving better total care to his patient. He informs the patient of the problem, attends to the soreness, educates in how to care for the condition, avoids unnecessary drug costs, avoids the problem associated with compliance of drug therapy, illness and anxiety, and finally fulfills the role of a teacher in being a doctor.

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The Postopiate Syndrome

Irving D. Royce, M.D.

Abstract: The description of a previously unrecognized disease entity, the postopiate syndrome, is presented plus a rationale for treatment. At the time the patient requests treatment, he no longer is addicted to drugs but must rely upon various medications of the sedative-hypnotic group to control anxiety, insomnia and depression. These symptoms frequently are resistant initially to the usual doses but respond to higher doses and to combinations of medications. Results of treatment described, however, are in sharp contrast to results of other therapy including methadone in curbing the need to return to heroin and in allowing the patient to become a happy and productive citizen.

During six months in a general psychiatric practice, a number of patients under 30 years of age were found to be suffering from an anxiety which resisted the usual tranquilizers and medications of the sedative-hypnotic group. About half of them had been subjected to unusual emotional strain; however, the others had used narcotics, especially heroin, regularly for a period terminating anywhere from five years to one month before starting psychiatric treatments. Some of their anxiety may have been released in a "rebound" way after months or years of suppression by "hard" narcotics, but the central nervous system may have been impaired in a manner which cannot yet be demonstrated anatomically or clinically. Evidence of the malfunction of the brain and spinal cord is that, after opiate withdrawal, ". . . patients often complain of weakness, insomnia, and nervousness for several months thereafter, and metabolic and physiological changes frequently persist for up to six months."[1] These changes may persist longer than six months. The disease referred to is the "postopiate syndrome."

The history of the origin of the anxiety symptoms helps to differentiate these former narcotics users from the psychiatric patients with severe anxiety secondary to a serious psychological conflict. Both groups have a syndrome of anxiety depression in all its disguises and therefore the two groups cannot be differentiated on the basis of signs or symptoms. Those patients accustomed to a freer lifestyle (long hair, simple clothing, less interest in marriage) are more likely to have used opiates than those who always accepted society's restrictions. But the important fact is that there is no need to differentiate between these groups of patients from the point of view of therapy.

The anxiety which may or may not be severe is characterized by several factors. First, the long-acting barbiturates such as phenobarbital and the "minor tranquilizers" such as meprobamate and chlordiazepoxide are either not effective at any dosage or effective only at doses which are toxic. Second, some antianxiety agents are effective at nontoxic doses such as the short—and intermediate—acting barbiturates (Seconal and Tuinal) and miscellaneous medications (Quaalude, Placidyl, Valium and Doriden). In many instances, however, especially in the postopiate syndrome patient, the discomfort returns too soon. This creates a situation in which the patient exhausts his prescribed medication for that particular 24-hour period and either starts that prescribed for the following day or obtains additional drugs elsewhere. In these instances "Multiple-drug therapy is justified if it provides greater efficacy than can be achieved with full doses of single drugs. . . ."[2] Adequate or even not quite adequate therapy helps to prevent the patient from returning "to the streets" where he again is exposed to counterfeit drugs and opiates which always appear to be available whereas methaqualone is not. The latter drug, not narcotic or a barbiturate, has been the single most important medication in treating this syndrome.

One additional factor is important. The patient should be eliminated as a candidate for therapy who does not really need medication regularly and who would be using it to get "high" rather than for a genuine medical purpose. To do this, information may be used from the patient's present illness, his medical and psychiatric history, results of urinalysis (for drugs) and the psychiatric examination including in some cases

results of narcosynthesis under Pentothal plus a notation of the degree of tolerance of the patient to Pentothal. The results from the Minnesota Multiphasic Personality Index, a psychological examination that takes the patient 1½ to 3 hours to complete, may be used as an aid in the clinical findings.

Treatment

Treatment of the postopiate syndrome is more difficult than the diagnosis because of the patient's high tolerance to medication. Usually he stopped using opiates months or years before the initial visit to the physician. On his first visit he reveals that he has been taking high doses of methaqualone, such as eight tablets per day, plus additional medication, possibly a short-acting barbiturate. Since the abrupt withdrawal of large doses of a barbiturate is very likely to produce seizures which cannot be prevented by anticonvulsants,[3] there is the probability that the rapid reduction of methaqualone may cause an abstinence syndrome, "The patient should be given sufficient quantities of whichever drugs are necessary to suppress severe withdrawal symptoms. . . ."[4]

In many of these cases the patient knows where he can obtain at some price whatever dosage of the drug he needs in order to remain comfortable. One of our jobs in rehabilitation, therefore, is to keep him from needing to go back to his "connection." The physician must offer some degree of relief through medication. "Many workers have pointed out the gross inadequacy of using total abstinence (from methaqualone) as the sole criterion of improvement. . . . Considerable improvement (in his relationship to people and in his ability to function productively) . . . may take place even when the use of the drug has only been reduced rather than completely eliminated."[5]

When the patient insists upon medication to help overcome fatigue, especially in the morning, coffee or tea on arising should be recommended especially if he is physically healthy. If fatigue continues as a serious complaint, tricyclic antidepressants will help in some cases. When complaints persist, especially in the presence of signs or symptoms indicative of depression such as depressive facies, then a stimulant should not be withheld. In 1972 in a general practice in England, 31 patients who had been taking amphetamines under a physician's care for at least six months were denied the drugs. "Significant depression" was detected in 11 of them, one had to be hospitalized for psychiatric reasons and two committed suicide.[6]

My experience indicates that chlorpromazine and other major tranquilizers or amitriptyline and other tricyclic antidepressants, when given concurrently with methaqualone, decrease the dosage of methaqualone required.[7] This combination does not appear to decrease methaqualone's ability to ward off the need for returning to opiates. It should be possible to keep the dosage of methaqualone to a maximum of 600 mg per day when these combinations are administered.

Psychotherapy at first is supportive. Nevertheless after eliminating those patients whose manipulations would be antitherapeutic, the others gradually reveal the analytical basis of their anxieties by emotional reactions to the physician, nurse, or other office personnel. The physician may use transference interpretation to reveal the unconscious meaning to the patient who may repeat the same emotional response or may describe situations in which he reacted in the same manner to someone outside the office. Group therapy also is offered once each week.

Discussion

There have been no previous guidelines for recognition or treatment of the postopiate syndrome. Hopefully now other physicians not only will diagnose the condition but also use methaqualone, when indicated.

Many physicians may fear the possibility of the drug's abuse, especially because of the epidemic character. "Simply because a drug can be abused and cause serious trouble if taken in extremely large amounts by a few persons does not mean that the drug used in appropriate amounts is necessarily bad. . . . Part of the problem is that while everyone agrees that it is right for pills to be used to relieve real suffering and wrong for them to be used for pleasure, many patients have . . . problems which fall somewhere between these two extremes."[8] The author presents as a common acceptable example ". . . taking 5 mg dextroamphetamine to stay awake and study."

The primary goal of drug abuse prevention programs is "to achieve a situation in which treatment is so readily available that no man can say he committed a crime because he couldn't get treatment," according to Dr. Jerome Jaffe, at the time head of the Special Action Office for Drug Abuse Prevention.[9] He was discussing the metha-

done programs. Many of these patients will experience the postopiate syndrome; however, if medical treatment is available (enough physicians experienced in use of methaqualone, for example), they will continue their rehabilitation into a productive life.

Presently about 25% of the patients in the methadone program at Jackson Memorial Hospital and about 40% in the program at St. Lukes, both in Miami, stay with methadone for 12 months or longer.[10] One year ago 10% of the nation's 600,000 heroin addicts were receiving methadone;[11] and of the 600,000 only 17% used methadone to be able to live a productive life, according to Dr. Carl Chambers, director of addiction sciences at the University of Miami School of Medicine.[12]

The postopiate syndrome patients in my practice are living a productive life without narcotics. They need the medical community to recognize their disorder, however, and if necessary establish some sort of guidelines to allow them to be treated with methaqualone, yet prevent the drug from being abused.

Following is the report of a typical case.

The patient, a 24-year-old single white man, was seen for the first time on January 7, 1974, upon referral by another patient. He was employed as a carpenter.

While in the armed forces in Vietnam he had injected "95% to 100% pure heroin" regularly for six months in an amount which would have cost $300-$400 per day in the United States. When he returned to this country two years previously he could find no heroin equivalent to the amount he took in Vietnam at prices he could afford, consequently he had stopped taking opiates of any kind. To decrease severity of withdrawal symptoms, he took large amounts of methaqualone plus secobarbital.

The patient reported that he became very irritable, hostile and depressed when he became tired, especially on the job and that weakness, nervousness and irritability had begun about the time he stopped taking heroin. He was taking 30 to 50 tablets of Quaalude plus 50 capsules of Seconal each week. Elavil did not help. He lacked the energy to work properly unless he also took at least one Biphetamine '20' capsule on arising. Neither coffee nor caffeine tablets were effective in any dosage.

Physical examination revealed no abnormalities and urine screening only methaqualone. Psychiatric evaluation revealed a cooperative young man who related well to the examiner with principal complaints of severe weakness during the day and nervousness both day and night. The diagnosis was postopiate syndrome with neurasthenic reaction and anxiety. He refused electroshock treatments.[13] He also refused hospitalization.

Following his first visit he was treated with one Desoxyn Gradumet tablet daily and about ⅓ the dosage of Quaalude he was taking but no barbiturate. This had only a mild effect upon the symptoms. On the second visit Quaalude was increased to 30 tablets per week,[14] Desoxyn Gradumet to seven 15 mg tablets per week and Tuinal was added, one capsule at bedtime each day.

The patient was seen at intervals of approximately seven days and the medication was decreased gradually. On his last visit (April 8, 1974) he was taking 17 Quaalude tablets per week, one or two 5 mg tablets of Desoxyn daily, and one Tuinal capsule each night. He has lost no time from work, is no longer irritable and reports no further arguments.

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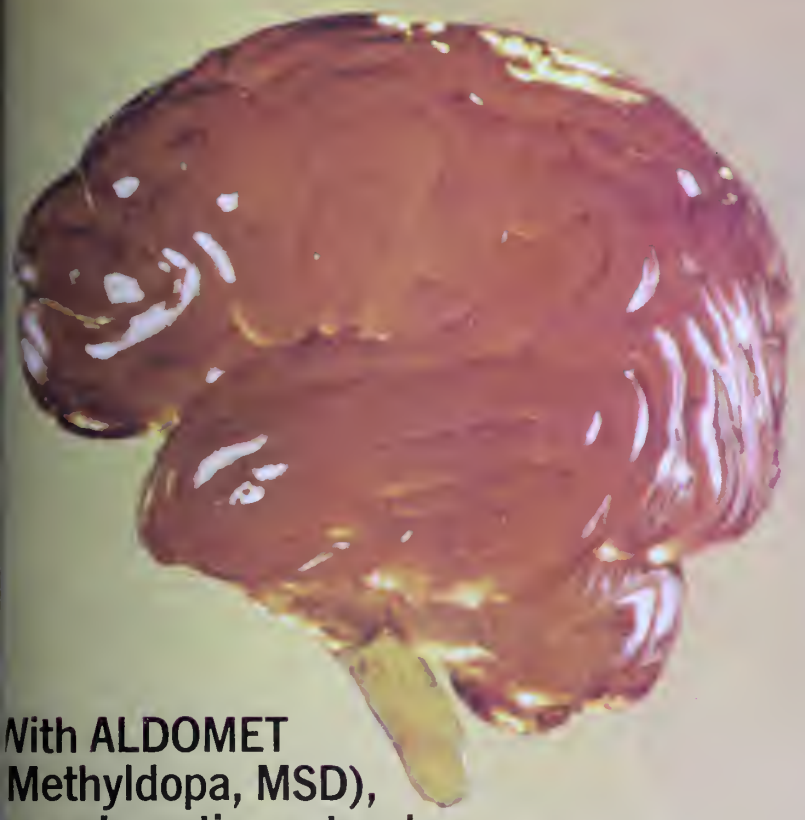

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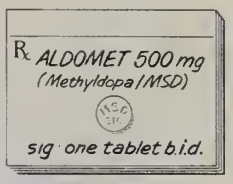

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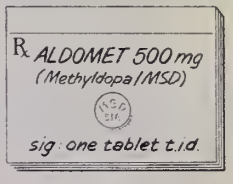

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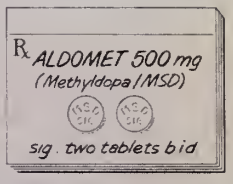

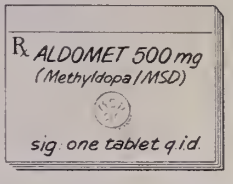

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, ma be seen during initial therapy or when dosage i increased. Headache, asthenia, or weakness ma be noted as early, transient symptoms. Symptom associated with effective lowering of blood pres sure are occasionally seen and include dizzines lightheadedness, and symptoms of cerebrovascula insufficiency. Angina pectoris may be aggravate Symptoms of orthostatic hypotension may occu if symptoms occur, reduction of dosage is sug gested. Bradycardia, nasal stuffiness, mild drynes of mouth, and gastrointestinal symptoms includin distention, constipation, flatus, and diarrhea occu occasionally; these generally can be relieved b reducing dosage. Nausea and vomiting have bee reported in only a few patients. Sore tongue "black tongue," pancreatitis, and inflammation salivary glands may occur.

Weight gain and edema occur infrequently and a relieved by administering a thiazide diuretic; edema progresses or signs of pulmonary conge tion appear, discontinue drug. A rise in BUN h been observed. Other rare reactions include brea enlargement, lactation, impotence, decreas libido, skin rash, mild arthralgia, myalgia, pare thesias, Bell's palsy, parkinsonism, psychic d turbances including nightmares, reversible mi psychoses or depression. Urine exposed to after voiding may darken because of breakdown methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 m daily when following previous antihypertensi agents other than thiazides. Maximal recommend daily dose is 3.0 g. Patients with impaired ren function may respond to smaller doses than p tients with normal kidney function. Syncope older patients has been related to increased sen tivity in those with advanced arteriosclerotic va cular disease; this may be avoided by lower dos Tolerance occasionally seen either early or la but more likely between second and third mon after initiation of therapy; increased dosage combined therapy with a thiazide frequently stores effective control.

How Supplied: Tablets, containing 250 mg meth dopa each, in single-unit packages of 100 and b tles of 100 and 1000; Tablets, containing 500 methyldopa each, in single-unit packages of 1 and bottles of 100.

For more detailed information, consult your M representative or see full prescribing informati Merck Sharp & Dohme, Division of Merck & Co., I West Point, Pa. 19486

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Special Articles

Preceptorships Revisited

Richard C. Reynolds, M.D.; Alice H. Murphree, M.A., and Samuel A. Banks, Ph.D.

Abstract: A two week preceptorship program for medical students of the University of Florida College of Medicine is described. An evaluation of this educational experience by both the doctors and students indicates that students perceive the learning of patient management skills as an important feature of their preceptorship. Students also identify this brief preceptorship as a successful means of becoming aware of social factors and institutions that affect the delivery of health care to patients. This preceptorship program remains successful because some Florida physicians make available to medical students their practice and homes. Medical students are able to immerse themselves briefly into the practice of their preceptor and experience the privileges and problems, the rewards and rigor of medical practice.

Medical education has always involved a student physician learning from a veteran practitioner. The acquisition of clinical skills and wisdom is largely, therefore, the result of practical preceptorship experience. Prior to the Flexner Report in 1910, clinical medicine was commonly taught to student apprentices by established physicians. The Flexner Report, however, emphasized the importance of understanding science as it applied to the practice of medicine.[1] Subsequently, more medical schools encouraged scientific studies and clinical research. University teaching hospitals became the accepted settings to care for the patient population particularly suitable for both medical education and research. Since World War II undergraduate and graduate medical education programs have become limited almost exclusively to the teaching hospital. Full-time medical school faculty has assumed increasing responsibility for teaching medical students and housestaff. It is now possible for students in many medical schools in this country to spend the entire seven to nine years of formal medical education cloistered in a university teaching hospital. During this period there may be, for medical students and housestaff, little, if any, interaction with practicing physicians. Similarly, there often are few opportunities to appreciate the social dynamics of communities and families in which medical practice and illnesses occur.

In 1969 the University of Florida College of Medicine initiated a new medical curriculum. Among the innovations, the basic medical sciences were shortened to a one year sequence focused on organ systems and requiring integrated team teaching. The final 18 months of the four year curriculum were designated for medical student electives. The clinical clerkship rotations were sandwiched between the basic medical sciences and elective experiences. In addition to the traditional training in medicine, surgery, pediatrics, obstetrics, and psychiatry, there was included a five-week community health and family medicine clerkship. A description of this clerkship and an evaluation methodology to ascertain its worthiness have already been described.[2,3]

A prerequisite for all student experiences during the community health and family medicine clerkship is that they take place in a setting outside the university teaching hospital. One possible selection for a medical student is a two-week preceptorship with a practicing physician. This

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report describes the organization and evaluation of this preceptorship program during 1971 and 1972.

Organization of Preceptorship Program

Faculty from the Department of Community Health and Family Medicine enlisted the support of the Florida Academy of Family Physicians to identify those physicians who would be willing to accept for two weeks a medical student into their practice and community. Physicians who expressed interest in the preceptorship program were asked to fill out brief biographical forms characterizing their family, education, background, style of practice, nonmedical interests and to identify living accommodations available to the medical students.

The Department sponsored each of two successive years a Preceptor Day. Physicians interested in the preceptorship program were invited to the College of Medicine. The faculty described for them the new medical curriculum, reviewed current trends in medical education and discussed the preceptorship opportunity for medical students. The practicing physicians were asked to share their thoughts concerning appropriate educational experiences for medical students during the clerkship. The physicians also met with medical students.

The physicians on the preceptor roster are predominantly family physicians, although some internists, pediatricians and obstetricians participate. Altogether more than 100 Florida physicians are identified as preceptors.*

Students selecting clerkship rotations, which include a preceptorship option, choose three physicians. The chairman of the department telephones one of them and confirms the dates of the preceptorship, describes the student, and answers any question the physician might have. Approximately 90% of the preceptorship assignments are consummated by a call to the first physician selected by the student. Subsequent to this phone conversation, a letter is mailed to each preceptor again identifying the student, confirming dates of the preceptorship and briefly reviewing the program. A copy of this letter is forwarded to the medical student along with the home and office telephone numbers of the physician. The student calls the preceptor several days before arrival to arrange a suitable time and meeting place.

Following the preceptorship, the physician is asked to grade the student's performance based on five considerations: attitude toward experience, awareness of community impact on health, energy and enthusiasm, medical-technical knowledge, and student-patient relationship. The student evaluates independently the preceptorship experience of the clerkship.[2] He or she also writes a brief paragraph of observations during the two week stint. The department chairman then writes to the preceptor including in the letter excerpts from the student's evaluation. Each preceptor averages about one student a year. The preceptor is identified as a faculty member of the Department of Community Health and Family Medicine and is listed in the catalog of the College of Medicine.

Results

During 1971 and 1972, 72 students participated in a two-week preceptorship with 58 physicians in 31 different locations. All but six preceptors were in Florida. Thirty-four of the doctors practiced in predominantly urban communities, 24 in rural areas. Forty-three students selected urban sites, and 29 chose rural settings.

Each student, on completing the preceptorship, evaluated the experience by responding to ten questions. Each question was followed by a brief description to define better its scope and intent. Some of these questions and explanations follow:

1. To what degree were you made aware of specific nonphysician resources for patients during your preceptorship?

Examples of such agencies and individuals are social workers and welfare personnel, visiting nurses and public health nurses, mental health workers, health representatives in community action program, Florida Crippled Children's Commission, Florida Council for the Blind, Vocational Rehabilitation counselors, occupational therapists, physical therapists.

2. From your preceptorship experience how would you rate the effect of economics, education, family, occupation, race and religion on patients' health?

Keep in mind that such social factors often are expressed in concrete organizations. For example, education is offered by day care centers, nurseries, and the family as well as formal school systems. Businesses, banks, loan companies, etc, may affect occupational and economic factors. Racial attitudes may be transmitted both informally and through such formal organizations as biracial committees, religious groups, and governmental agencies.

3. To what degree did you see economics, education, family, occupation, race, and religion affecting the patients' willingness to cooperate in his medical care?

*Any Florida physician interested in serving as a preceptor is invited to write the Department of Community Health and Family Medicine, Box 712 MSB, J. Hillis Miller Health Center, Gainesville 32610 in care of Richard C. Reynolds, M.D.

TABLE 1. — Student Responses to Questions Concerning Impact of Preceptorship Experience.

Question Student's awareness of:	No answer or does not apply	None 0	Low 1+	High 2+
1 Nonmedical resources affecting health care	3 (0.4%)	16 (20%)	41 (53.2%)	17 (22%)
2 Social factors affecting health	4 (0.5%)	1 (.01%)	33 (43%)	39 (51%)
3 Social institutions affecting patient's attitudes to health care	2 (0.3%)	1 (.01%)	31 (40.2%)	43 (53.8%)
4 Degree of skills learned from preceptor regard management of minor or chronic complaints	1 (01%)	1 (01%)	15 (25%)	43 (71.6%)

NOTE: Not all students answered every question. Question #4 was added shortly after the evaluation began.

These social factors may influence, among other attitudes, the patients' understanding of what constitutes health or illness, what significant symptoms are, how soon he should go for care, his willingness to follow instructions, and ways of appropriate payment.

4. In treating ambulatory patients, many of whom present with minor illnesses or chronic disorders, what degree of skills did you learn from physicians with whom you had contact that would help you in management of these patients?

The responses of the students to these questions are presented in Table 1.

Ten students selecting preceptors with urban practices were compared with ten students choosing physicians practicing in small rural communities. Their responses to the experience were almost identical.

Each student was also asked to record the most significant learning experience and the most disappointing feature of the preceptorship. These responses are summarized in Table 2.

A summary of the grade sheet data from the physician evaluations of 34 medical student performances in 1972 is presented in Table 3. The physicians were consistently laudatory of the medical students. A similar scale used by full-time academic faculty and senior residents in other settings resulted in a more critical appraisal of the student. Since the preceptorship occurred either at the end of the student's second year or the beginning of the third year, the physician

TABLE 2. — Student Definition of Significant and Disappointing Features of Preceptorship.

SIGNIFICANT LEARNING EXPERIENCES

Type	# of Students
Content of practice	27
Dynamics of practice	24
Physician's lifestyle	16
Physician's skill	7
Student's "Doing"	3
Learned about L.M.D.'s and care	4
Learning technical skill	3
Patient management	3
Evaluate own education	2
Economics of care delivery	2
"First line" of health care	2
Seeing another point of view	1
Seeing patient as part of family	1
The whole milieu	1
	96

DISAPPOINTING FEATURES

Type	# of Students
Nothing	20
Not "doing" enough	21
Time too short	11
Dynamics of practice (boring, routine)	8
Content of practices (type of cases)	6
Student's lack of technical skill, education	3
Cost of care, practice	2
Physicians' skill (lost, forgotten)	2
Leaving wife	2
Racial dynamics	1
Social dynamics	1
Lack of emphasis on differential diagnosis	1
Patients not recognizing student as doctor	1
Lack of time to evaluate, too busy	1
Not enough deliveries ("unbusy")	1
Teaching too elementary	1
Too shallow re: philosophy of medicine	1
Geographical isolation	1
Political difference with doctor	1
	85

(Some students responded in more than one category.)

TABLE 3. — PRECEPTORSHIPS—1972.

SUMMARY OF GRADE SHEET DATA

	E*	S	P	UA	UE
Student's attitude toward experience	31	4	0	0	1
Student's awareness of community impact on health	19	14	0	0	3
Energy and enthusiasm	22	9	0	0	0
Medical technical knowledge	21	12	2	0	0
Physician/patient relationship	27	8	0	0	1

Overall Grade	A	B	C	D
	26	8	0	0

*E = Excellent
S = Satisfactory
P = Poor
UA = Unacceptable
UE = Unable to Evaluate

often commented favorably on his clinical expertise.

Even a brief preceptorship for medical students needs clear objectives. It should illustrate for the student the nature of illness seen in a community, and particularly how patients themselves identify their needs for medical care. Certainly, the effect of illness on a patient's family is shown better in a community practice than in a referral hospital setting. The preceptor physician tries to demonstrate for the student how he or she copes with the physical and emotional ills of his patients. The physician imparts to the student his concern for patients, approach to troublesome patients, and, at times, problems with difficult colleagues. In brief, a preceptor shows the student practice as it is, without frills or embellishments. The rigors of practice, rewards and problems are identified by the preceptor and discussed with the student. He helps the student understand that his role in a community extends beyond immediate medical practice. This includes participation in local, state and national medical organizations, membership in hospital committees, and responsibility for selected nonhealth community activities.

Students have mixed expectations from a preceptorship. Basically, they want to see what a physician does, how he got started, why he selected a certain location, and how he built a practice. The students want to see the types of illness cared for in the office and community hospital and contrast it with their own experiences in the university hospital. They want insights into how a physician organizes his practice and exposure to the rigor and relentlessness of practice.

The students rate high the clinical skills learned from the preceptor pertinent to the management of minor and chronic complaints. In addition, they are able to discern some of the nonmedical factors that affect health care delivery and the nonmedical resources that contribute to health care.

It is problematical whether these same preceptors would have been as successful in teaching their clinical skills in the university teaching hospital. The patient populations and clinical settings are truly different. The practicing physician is most comfortable in his customary environment which, in itself, adds a needed dimension to the present educational settings of medical students.

No evidence exists that preceptorships will affect either type or location of practice of the student. In fact, there is a suggestion that one preceptorship program actually resulted in a push toward specialty practice.[4]

The appropriate length of a preceptorship is undetermined. This two-week preceptorship is brief, but appears sufficiently long for the student to capture the essence of his preceptor's practice. A few students are selecting a longer experience during their 18-month elective period following the clinical clerkships. Physicians consistently say that they have to cut back their practice one fourth to one third in order to accommodate the medical student. Otherwise, they do not have the time to fulfill their obligations to the student and to their patients. Since the preceptor is not reimbursed for his efforts, a longer preceptorship conceivably might discourage some busy practitioners. Because of the intense student-physician relationship (over 90%

of the students live in the home of their preceptor) two weeks has proven a reasonable duration for this learning experience.

The preceptors appear to enjoy their brief contribution to medical education. In addition to their grading of the student, they often add comments about him or her or the preceptorship experience. Invariably these are complimentary. During the first six months of the preceptorship program, a faculty member called each physician to ask him to anticipate the student's response to the evaluation of his preceptorship. The physician and student responses were similar.[3]

The compatibility of preceptor physician and medical student is remarkable. During three years and involving more than 100 students, there has been only one mismatch where both parties felt uncomfortable. Some male physicians have requested not to have female students (one said his wife might not understand this was an educational experience) and black students have usually opted for black physician preceptors. One white student, a graduate of a predominantly black college, selected a black preceptor.

Summary

For three years the University of Florida College of Medicine has sponsored a two-week preceptorship for medical students with family physicians. This intense educational experience in which a student is immersed in the practice, life, and community of a family physician has been successful and rewarding to both participants. Even the brief period appears long enough for the student to witness and perceive the community and family factors which influence the patients' health and their medical care. During the preceptorship students rate highest the clinical skills learned from the preceptor. For some students this remains their only contact with community medical practice until they conclude their residency years.

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Acute Drug Reaction in a Hospital Emergency Room

*A Demographic and Social Assessment**

Carl D. Chambers, Ph.D.: David M. Petersen, Ph.D., and Sandy C. Newman, M.A.

Abstract: This study investigated a sample of persons treated for acute drug reactions (overdoses) in a hospital emergency room setting to determine the general characteristics of these drug abusers and the incidence of drugs responsible for their admission. Detailed information is provided on the race and sex composition of these drug abusing patients and comparisons are made with the general population of the area serviced by the hospital. The sample consisted of 1,128 persons who entered Jackson Memorial Hospital, Miami, (Dade County) Florida during 1972. A profile of the *typical* admission for emergency care of a nonfatal overdose reveals a white female, who is 18-24 years old and who has overdosed on a single legally manufactured and distributed substance, usually a sedative.

The use and misuse of drugs is obviously extensive in the United States. Although statistics abound in a bewildering array, existing data are admittedly incomplete and inaccurate. No consideration would be complete without an examination of one of the most crucial and vexing aspects of the drug problem—the acute drug reaction (overdose). Despite a growing body of literature on the emergency treatment of acute drug intoxication,[1-7] there has been no determination of the characteristics of those individuals treated for nonfatal acute drug reactions. This paper provides basic source data on persons admitted for treatment of drug overdoses in a hospital emergency room setting.

Records for 1,128 persons treated for acute drug reactions (not including hepatitis, poisonings and persons seeking addiction detoxification) at Jackson Memorial Hospital, Miami, during 1972 were reviewed to form the basis of this report. In the main, evidence regarding the overdose situation was based upon a history obtained from the patient or some accompanying person by the attending staff in the emergency room. In addition, for many cases verification of the drug abuse diagnosis was derived from laboratory analysis. Some 125 different legal and illegal substances were identified as the drugs which caused these acute overdose reactions.

General Characteristics of Patients

The racial distribution for patients indicates these victims significantly more often were white than black (66.9% as against 33.0%). Acute drug overdose admissions also varied according to the sex of abusers, some 58.6% were females. White females were more likely to be admitted than any other race/sex grouping, accounting for over one third (38.4%) of all admissions. The overwhelming majority of reactions occurred among the young. Almost 60% were individuals under 25 years of age, while more than three fourths (78.2%) were under 35.

Additional information relative to these patients includes the number of substances responsible for their admission to the hospital emergency room. The greatest majority (63.8%) indicated that they had used only one substance (excluding alcohol) during that period immediately prior to their acute reaction. In almost one fourth (19.6%), however, two or more substances were used together. Quite surprisingly, alcohol use was present in combination with other substance abuse for only 10.9% of all admissions.

Behavior which we call drug misuse may range from unwise self-medication or consuming substances for relief or avoidance of tension to drug-taking for euphoric effect ("kicks"). These accidental overdoses account for almost half (47.4%) the admissions. At the same time, however, some one fourth (24.1%) of these patients admitted that they were consciously trying to kill themselves.

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*For interested readers a copy of the complete tables used in preparing this article are available from the senior author upon request.

Primary Substance of Abuse for 933 Acute Drug Reaction Cases

Each patient admitted for treatment was classified according to the primary substance responsible for his admission. For those patients who had abused two or more substances, designation of the main substance was determined on a case to case basis according to the amount of each substance ingested and/or whether the substance(s) could be identified as having legitimate medical usage. Information regarding the substance used prior to hospital admission was unknown for 195 patients (17.3%) treated during the study period.

The great majority of these admissions were for the misuse of legally manufactured and distributed drugs. More than three fourths of all admissions (79.4%) were identified as resulting from substances available legally by prescription or over-the-counter without prescription. (We have no means of determining from the medical histories, however, by what means these patients acquired these drugs.) Moreover, over half (62.3%) of all the acute reactions involved the misuse of one of the psychotropic drugs (sedatives, tranquilizers and stimulants). Overdoses from non-narcotic analgesics accounted for an additional 10.1%. Illicit substance abuse leading to emergency treatment was almost entirely accounted for by heroin (8.9%) and hallucinogens (8.8%).

General Characteristics Associated with Type of Overdose Substance

A comparison between those patients admitted for an overdose of an illicit substance and those admitted for treatment of a legal substance overdose was made for the 933 patients for whom this information was available. A distribution by sex reveals that both males and females are more likely to overdose on a legal rather than an illegal substance (64.2% male, 89.9% female). For persons in whom the overdose substance was one of the illicit drugs, males are overrepresented by more than 2 to 1. However, for those overdosing from the legally manufactured drugs, the situation is reversed or in excess of 2 to 1 females to males. Stated somewhat differently, 70.8% of all persons being treated for overdose involving illicit drugs were males while 67.1% of those who overdosed with a legal drug were females.

With regard to race, both the illicit and legal substance overdose patient was most likely to be white (55.7% and 71.4% respectively). The margin of difference, however, is much more striking for legal substance overdoses. The greatest majority of both races were found, however, to have misused a legal rather than an illegal substance (83.2% white, 71.3% black).

Whether an individual overdosed on a legal or illegal substance differed by age. The younger the patient, the more likely he was to be identified as an illicit substance abuser. Among patients overdosing with illicit substances, 78.6% were under 25 years of age compared to 50.6% overdosing with legal substances. Only two illicit substance overdose patients (1.1%) were over 34 years of age. Among the legal substance abusers, almost one fourth (24.5%) were persons 35 and older. The older the individual the more likely he was to be admitted from having abused a legal substance.

Additional data concerning the relationship between the type of substance precipitating the acute reaction and the sex and race of these patients was also computed. Comparing all four sex/race cohorts as contributors to specific overdose phenomena involving the illicit drugs, the most salient findings include the following:

Heroin overdose victims were most frequently (60.2%) males with some one third black males.

Hallucinogenic overdose victims were almost always (81.7%) males and more than twice as many white males as black males.

Inhalant/solvent overdose victims were most frequently (66.7%) males and most likely to be black males.

Stimulant overdose victims were most frequently (75.0%) males with twice as many white males as black males treated for overdoses.

Comparing all four sex/race cohorts as contributors to specific overdose phenomena involving the legal drugs, we find the following:

Methadone overdose victims were almost always (83.3%) males and twice as many white males as black males were admitted for this specific drug reaction.

Narcotic (excluding methadone) overdose victims were most frequently (53.8%) females with six times as many white females as black females.

Non-narcotic analgesics overdose victims were most frequently (74.4%) females with slightly more black than white females.

Tranquilizer overdose victims were most frequently (74.4%) females with more than twice as many white as black females.

Sedative overdose victims were most frequently (61.8%) females with some three times as many white as black females.

Stimulant overdose victims were almost equally divided between males and females (52.6% males, 47.4% females) although white males were the overwhelming major contributors with 47.4% of all stimulant overdoses.

Grouping the data to reflect specific race/sex cohort involvements and by ranking the three substances most prevalent in these involvements, the following differences emerged:

Among the 266 white males (28.6% of the total admissions where the substance of abuse was identified)

37.6% ..... Sedative overdoses
18.4% ..... Hallucinogen overdoses
17.7% ..... Tranquilizer overdoses

Among the 114 black males (12.2% of the total admissions where the substance of abuse was identified)

25.4% ..... Heroin overdoses
24.6% ..... Sedative overdoses
15.8% ..... Hallucinogen overdoses

Among the 370 white females (39.7% of the total admissions where the substance of abuse was identified)

42.7% ..... Sedative overdoses
32.7% ..... Tranquilizer overdoses
8.1% ..... Non-narcotic analgesic overdoses

Among the 182 black females (19.5% of the total admissions where the substance of abuse was identified)

26.9% ..... Sedative overdoses
26.4% ..... Tranquilizer overdoses
22.0% ..... Non-narcotic analgesic overdoses

In order to place these data in perspective with the general population of the area serviced by the hospital, race and sex comparisons were made with that general population. Females and blacks of both sexes are most over represented in the emergency room for acute drug reactions.

This study was designed to assess the emergency room admissions for acute drug reactions (overdoses) from two perspectives: race and sex cohort distributions for these victims and specific substances which precipitated the reaction. The significant findings are as follows:

Grouping the data to focus upon proportional representation of the specific race and sex cohorts it was found that females and blacks of both sexes were over represented.

Grouping the data to focus upon the specific substance which precipitated the overdose and the sex/race cohort which contributed the most cases revealed the following:

Overdoses from Illicit Drugs
- Heroin ..... Black Males
- Inhalants ..... Black Males
- Hallucinogens ..... White Males
- Stimulants ..... White Males

Overdoses from Legal Drugs
- Methadone ..... White Males
- Other Narcotics ..... White Females
- Non-narcotic Analgesics ..... Black Females
- Tranquilizers ..... White Females
- Sedatives ..... White Females
- Stimulants ..... White Females

And finally, examining race and sex as independent variables produced the following data regarding the substance most likely to precipitate an overdose reaction for each race/sex grouping:

White males were most often admitted for sedative overdoses.

White females were most often admitted for sedative overdoses.

Black males were most often admitted for heroin overdoses although sedative overdoses were almost as common.

Black females were most often admitted for sedative overdoses although tranquilizer overdoses were almost as common.

A profile of the *average* admission for emergency care of an acute drug reaction, would undoubtedly reveal a white female, who is 18-24 years old and has overdosed on a single legally manufactured and distributed substance, usually a sedative. What this study could not address were the overdose victims who were "treated" or survived without treatment outside the hospital. Our impressions are that most overdoses and other adverse reactions to the illicit drugs are not being managed in emergency facilities.

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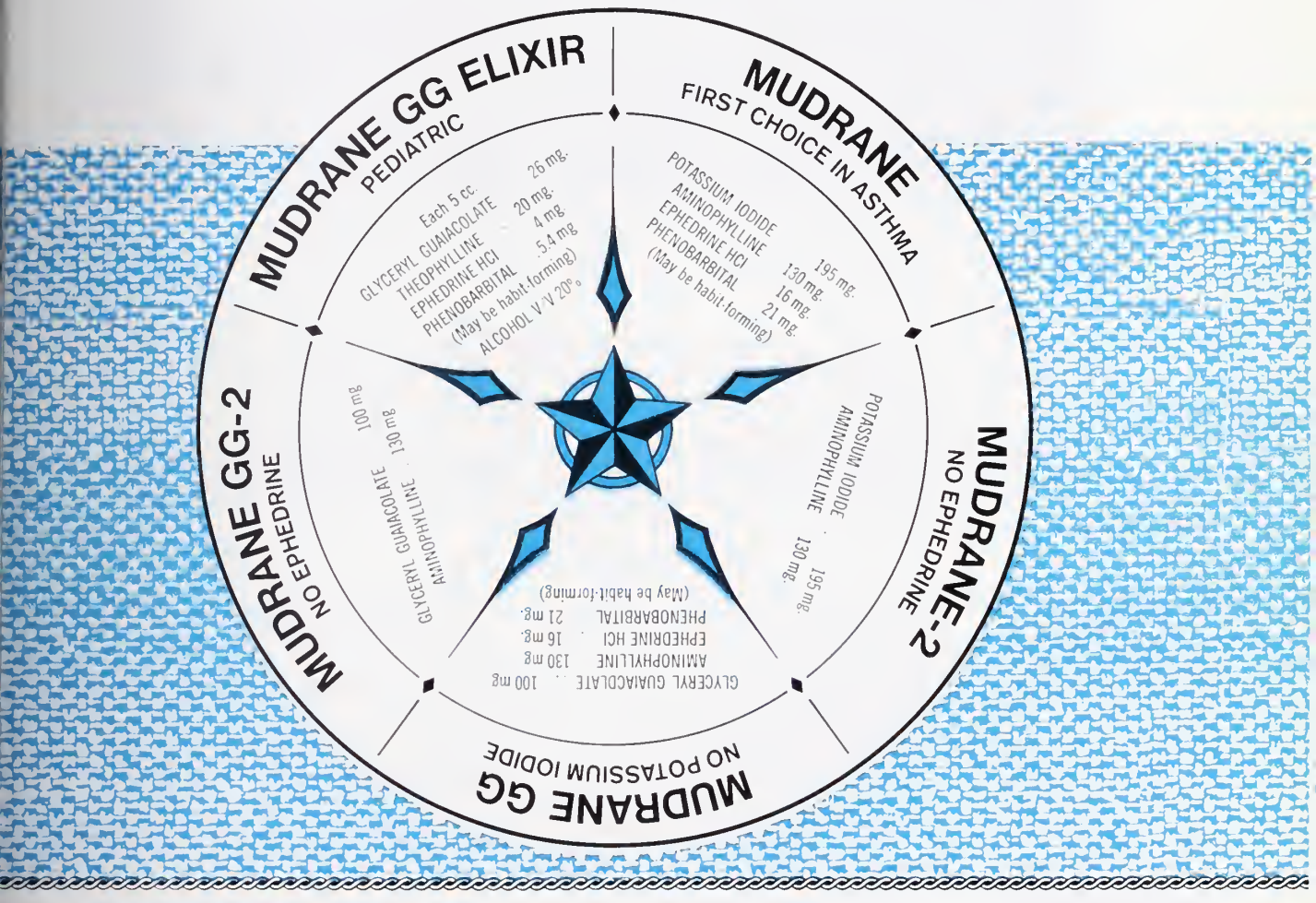

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CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

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TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

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VERNON B. ASTLER, M.D.

ORGANIZATION

Vernon Bensen Astler

It was a good day for organized medicine in Florida when Vern Astler came to Delray Beach following his surgical training at the University of Michigan. I can say from my eight years of friendship and association with Vern that he is outstanding and that he was destined for leadership.

He is a man of extremely high principles. To him right is right and wrong is wrong. There is no in-between ground or gray area. He will speak for and support what he feels is right and best for the practice of medicine and for our patients, the citizens of Florida. His stand will be clear, unequivocal, eloquently stated and unmistakable. He will disagree on principle but it will not be personal.

One quickly knows exactly where Vern stands on an issue because he will not hesitate or hold back in his feelings thereon; however, when the issue has been stated, discussed and/or settled, there is nothing personal as far as he is concerned —no resentment, no grudges, no feeling of righteousness. He is what he is and one accepts him that way. He is very intelligent, alert and extremely capable both in his surgical practice and in his many and varied activities and interests. These include piloting an airplane. He is articulate with a mind like a computer, yet he can quickly adjust his ideas, thoughts and expressions to fit the situation and the person or group and make everyone feel at ease and comfortable. He does not talk down to anyone and he can generally win a person over by his logic, clarity and sincerity.

He is the kind of leader organized medicine needs right now and the position has found the right man. He will be a dynamic, forceful and respected leader. He will represent our profession with dignity, honor and pride. I can assure Florida medicine of this from my knowledge of and association with Vernon Astler. We are fortunate indeed to have him now.

May God grant him continued good health and the energy and capacity to use his many talents and assets during his presidency of our beloved Association.

GEORGE S. PALMER, M.D.
TALLAHASSEE

Clyde M. Collins, M.D.
Compassionate Editor, Whole Physician, Humanitarian

Some men are filled with a life-force for good and others for bad. Some are filled with hope and others with despair. Some gear themselves to unity and others to divisiveness.

Clyde Collins' life-force is for good; it has been for a half century. He is filled with hope and unity. Compassionate, understanding and concerned, he epitomizes the inner dignity which should belong to all physicians.

The son of a Methodist minister, tempered in general practice by delivering medical care to deprived patients in the coal mining regions of western Virginia for two years, Clyde came to Jacksonville in 1949 to begin residency training at Duval Medical Center, now University Hospital of Jacksonville. This association culminated in his being chief surgical resident in 1953. Shortly thereafter he was certified by the American Board of Surgery. In January 1975 he became president of the staff at University Hospital. During the intervening years, Clyde has given his time liberally in caring for the indigent patients of Duval County and in training interns and residents, many of whom have settled into productive practice in this area.

Clyde completed Emory University undergraduate school in 1937 and the Medical College of Georgia in 1942. Following an internship in Gainesville, Georgia, he entered the U. S. Army Medical Corps and spent three years serving his country. As a captain, while fighting on the Luxembourg border in December 1944, he and his unit were captured by the Germans. In the dead of winter, Clyde walked across Germany to Munich. Liberated a few months later, he was privileged to a train ride back across the same territory. Two years ago, after long service in the U. S. National Guard Reserves, Colonel Collins retired.

About 1948 while serving a residency at Grady Hospital in Atlanta, Clyde caught the eye of a pretty Grady nurse from Tampa. Her name was Mary McDuffy and she shortly became Mrs. Collins. Six children, Mary Stewart, Martha, Miriam, Clyde, Leo and Edward (twins), have blessed their home. They now span the continent from Boston University to the plains of Omaha and, of course, the banks of the St. Johns River.

Dr. Collins

Clyde's greatest pleasure, aside from his family and the practice of surgery, is swimming. He has a large pool at his home on the St. Johns River and early in the morning, each day of the year, weather notwithstanding, Clyde swims enough laps to keep himself in top physical condition.

Dr. Collins served as president of the Duval County Medical Society in 1968, a year of progressive achievement for Jacksonville medicine. From 1970 to 1975 Clyde, as editor, lent his talents to producing for us one of the finest state medical journals. He has a penchant for Journal covers, which began no doubt many years ago when he was editor of the county medical society Bulletin. The money "squeeze" has only recently dampened his enthusiasm for picturesque covers. His editorials are filled with Oslerian wisdom and his helmsmanship makes the Journal of the Florida Medical Association one of the best in the nation.

A credit for the past, no less for the future, for Clyde is a timeless man, a tireless physician, a humanitarian, filled with consideration, kindness

and thoughtfulness, not only for his fellow physicians but for patients and all humanity, great and small. We salute the forthcoming retirement of a great editor, one we shall all miss and all remember.

EMMET F. FERGUSON, M.D.
JACKSONVILLE

Dr. Ferguson is President of the Duval County Medical Society; Associate Editor of the Society's Bulletin and a practicing surgeon.

In Honor of Clyde Collins

The editor of a medical journal must be a special person with years of training in medicine which provides him with first-hand knowledge and skill to render discriminating judgments in highly specialized and technical areas. It is desirable that he have compassion and insight about the human condition—necessary qualities of a clinical specialist.

In addition, the editor must have a second specialty. It includes skills in communication, and knowledge of printing, publishing, advertising, economics, and business. It requires literary aptitude and interest over and above that of the average physician plus considerable on-the-job training.

Clyde Collins, our editor for five years, has these attributes and more. He is a friend to those with whom he comes in contact. He has exercised skill and judgment about the good of the Journal and improvement of Florida Medicine. On his shoulders have rested final editorial decisions. For example, no decision is so difficult as whether to reject a scientific article which may not be appropriate. Yet, when the decision has been made, his rejection note frequently is tempered with constructive comments for improvement, revision, or suggestions for submission to a more appropriate journal.

Clyde is also a husband, father, churchman, and amateur vocalist.

All of Florida Medicine join me in thanking Clyde for a job well done.

F. NORMAN VICKERS, M.D.
PENSACOLA

Dr. Vickers is an Assistant Editor of the Journal of the Florida Medical Association and a practicing internist.

Stands Out Above the Rest

Words often fail to convey the true gratitude that many of us who have close association with the Journal feel for Clyde Collins. Displaying a selfless dedication, unusual talent, and driving desire, Clyde Collins has demonstrated pride in his efforts to make this publication really sing. The "notes" he played created sixty masterpieces over the past five years. He left no page untouched as he worked diligently on cover, art, advertisements, editorials, scientific articles and the news of organized medicine. He believed the Journal must attain the same sophistication and expertise enjoyed by the medical profession. "This must be our image," he often said, and toward that end he marshalled a continual argument of reason and fact. Clyde actually loved the Journal. His pride and efforts beamed from every page. His many qualities contributed greatly to our Florida Medical Association, and I am sure he gave as much or more of himself as did any physician in the organization.

His personal life reveals the same characteristics. Recently Clyde not only returned to Oxford College of Emory as an alumnus, but also this time for Parents' Day. The president of the college, professors, and many other of his contemporaries seemed to glow in admiration as they talked to this extra special man. His charming wife, Mary, and their six children are extensions of Clyde's soft manners and personable ways.

Space really limits an adequate eulogy, but we of the FMA were most fortunate he shared with us. Yes, Clyde Collins represents a man who in life, at work, and at home truly "Stands Out Above the Rest."

JOSEPH C. VON THRON, M.D.
COCOA BEACH

Dr. Von Thron is a Past President of the Florida Medical Association and a practicing family physician.

Our Thanks to Clyde Collins

Clyde Collins has been editor of the Journal of the Florida Medical Association for the past five years and has done a very creditable job. His constant, unswerving devotion and attention has kept the Journal one of the better ones in the nation, and he deserves thanks from all of us.

To my notion, the Journal has four main tasks: to record what is new, educate, provide a forum for discussion, and chronicle the activities of the state medical association.

It was Clyde's duty and responsibility to choose the material for publication and select the articles.

The actions of our state association do not require the close review as do the articles which are for scientific interest, research or education, and it was in this organizational aspect, Clyde demonstrated his efficiency.

Since our Journal is a general one, the editor must be very clear about his audience. It is made up of all types of physicians with widely divided interests. Very often the editor is unable to know all the answers, but Clyde knew he could obtain sound advice from his editorial board.

The recent emphasis of our Journal to become more involved in continuing education is a reflection of the desire of the editor to emphasize this new phase of postgraduate education. Clyde was on the alert to promote this kind of learning.

Another item of responsibility requiring Clyde's attention, which is not as clearcut as the four previously mentioned, is the Journal's concern for ethical standards. This concern needs no emphasis as the relevance is as much apparent as ever.

Thanks, Clyde, for a job well done.

Floyd K. Hurt, M.D.
Jacksonvlle

Dr. Hurt is a Past President of the Florida Medical Association and a practicing radiologist.

A Tribute to Dr. Collins

It is with deep regret that we bid our editor and friend farewell. To me, these past five years have been a study in patience amidst frustration; a lesson in quiet humility, kindness and concern seldom seen in today's busy world.

The agonizing hours he has spent over whether to accept or reject an article and how to combat the ever rising cost of publishing the Journal; fighting sleep and fatigue many nights to meet an ever approaching editorial deadline; an ever increasing amount of letters to answer or to write to obtain something timely he felt the membership should know, and most of all, the time he has always made available to us for answers to our perplexing problems—these things, known only to those working closely to him, have earned our deepest respect and admiration and have made our job much easier and more pleasant.

It is with appreciation and sadness we say "thank you" to Dr. Collins with the following quotation:

There is a destiny that makes us brothers
None goes his way alone.
All that we send into the lives of others
Comes back into our own.
—Markham

Louise Rader
Managing Editor

Dr. Gerold L. Schiebler
The Journal's New Editor

DR. SCHIEBLER

Dr. Gerold L. Schiebler of Gainesville became Editor of *The Journal of the Florida Medical Association* with the May issue, the first physician from full-time academic medicine to serve in this position. Presently, Dr. Schiebler is Professor and Chairman of the Department of Pediatrics at the University of Florida College of Medicine. He has been an Assistant Editor of the Journal for a number of years, and prior to that time served as the Consulting Editor to the Journal for the Florida Pediatric Society.

Dr. Schiebler's primary professional interests have been various aspects of pediatrics and pediatric cardiology. With the collaboration of colleagues he has published more than 75 articles, 52 abstracts, two books, and six chapters in other books. He serves as a member of the Editorial Board of the journal, *Clinical Pediatrics*.

Dr. Schiebler began his teaching career at Harvard Medical School following an internship and residency in pediatrics and internal medicine at the Massachusetts General Hospital. He continued teaching and training in pediatric cardiology at the University of Minnesota Hospitals in Minneapolis, Minnesota, and then spent a year and a half in the cardiovascular laboratory of Dr. Earl H. Wood at the Mayo Clinic in Rochester, Minnesota.

In 1960, he joined the medical faculty at the University of Florida as Assistant Professor of Pediatrics (cardiology), becoming only the third pediatric cardiologist in the state. He became Associate Professor in 1963, Professor in 1966, and Chairman of the Department in 1968.

The College of Medicine class of 1971 at the University of Florida recognized Dr. Schiebler's "zealous attention to the Hippocratic ideals of teaching—creative, forceful and inspirational instruction—thereby bringing enrichment to the minds of students, excellence to his profession and distinction to himself," and presented him the Hippocratic Award for Teaching Excellence. He was the third faculty member to receive this honor. In 1973, the University of Florida Blue Key leadership fraternity presented to him the Distinguished Faculty Award and the following

year the Florida Heart Association honored him with the Distinguished Service Medallion.

The College of Medicine granted him a leave of absence in November 1973 to serve as Director of the newly-created Division of Children's Medical Services of the Department of Health and Rehabilitative Services of the State of Florida. Dr. Joseph C. Von Thron, President of the Florida Medical Association that year congratulated Governor Reubin O. D. Askew upon his choice of Dr. Schiebler, stating that he "represents one of the most competent, eloquent, energetic and motivated physicians in Florida. Not only has he been capable of resolving misunderstandings between the academician and practicing physician, but he has the capability of cementing relationships between physicians in government and physicians in private practice."

Dr. Schiebler returned to his full-time academic duties at the College of Medicine in January 1975.

Certified by the American Board of Pediatrics in 1959 and the Sub-Board of Pediatric Cardiology in 1961, Dr. Schiebler has been active in the American Academy of Pediatrics, Section of Cardiology; Southern Society for Pediatric Research; Northwestern Pediatric Society; American College of Cardiology; American Medical Association; Florida Medical Association; Florida Pediatric Society, and Alachua County Medical Society.

His FMA responsibilities have included membership on the Scientific Assemblies Committee, and Chairman of that committee when it organized the program for the Centennial meeting of the FMA in 1974. Also, during the past two years he has served as Chairman of the Council on Scientific Activities.

He is a native of Hamburg, Pennsylvania and was graduated magna cum laude from Franklin and Marshall College in Lancaster, Pa. in 1950, and graduated from Harvard Medical School in 1954. He married the former Audrey Jean Lincourt of Newport, R. I. They have six children: Mark, Marcella, Kristen, Bettina, Wanda and Michele.

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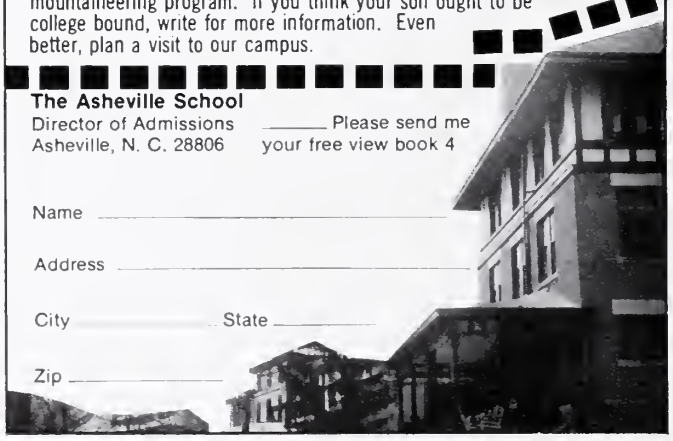

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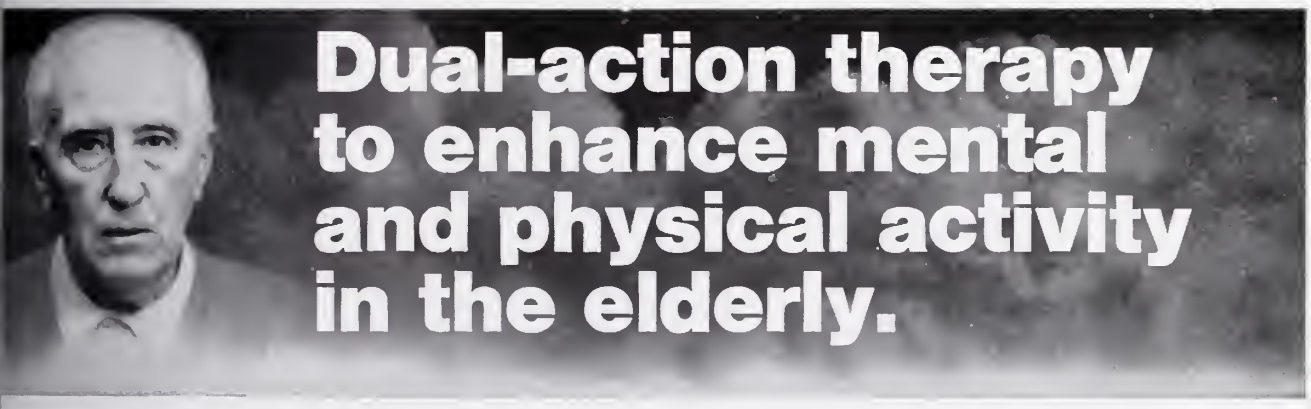

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Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.
SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.
PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.
CONTRAINDICATIONS: There are no known contraindications to Menic.

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The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology

X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W. B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

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Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

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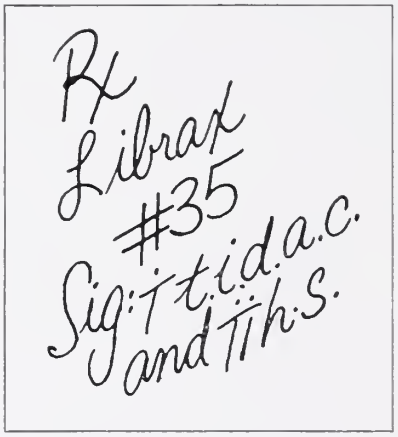

Initial therapy

The initial prescription allows evaluation of patient response to therapy.

Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan™)—bottles of 100 and 500.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

MAY

25th Annual Postgraduate Seminar, May 1-3, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

An Intensive Day in Intensive Care, May 3, VA Hospital, Miami*

Seminar Session, Department of Anesthesiology, May 5-9, University of Florida College of Medicine, Gainesville**

Multidisciplinary Approach to Management of Head and Neck Cancers, May 9-10, Auditorium, St. Augustine General Hospital, St. Augustine*

1975 Physician's Seminar on Respiratory Disease, May 9-11, Turtle Inn, Atlantic Beach. For information: Gerald N. Olsen, M.D., P.O. Box 8127, Jacksonville 32211

Cancers of the Breast, Colon and Lymphomas, May 9-11, Johns Island. For information: Rubin Klein, M.D., 1131 N. 35th Ave., Hollywood

Cardiological Cruise, May 10-17, S. S. Rotterdam, New York - Nassau - Bermuda - New York. For information: Tampa Tracings, Box 636. Oldsmar, Florida 33557

Family Practice Review Program, May 12-16, Gainesville Hilton, Gainesville**

The Anxieties of Doctors, May 15, Baptist Hospital, Pensacola. For information: Claude L. Brown, M.D., 176 Louiselle St., Mobile, Ala. 36607

Master Approach to Cardiovascular Problems, May 15-17, Walt Disney World, Orlando*

5th Annual Radiotherapist Clinical Research Seminar, May 15-17, Flagler Inn, Gainesville**

Radiation Oncology, Indications for and Treatment of Cancer Patients, May 16, Auditorium, Parkway General Hospital, N. Miami Beach*

The Spinal Cord Injured Patients, May 16, Miami*

Recent Developments in Dermatopharmacology, May 16-18, Hyatt House, Miami Beach. For information: Philip Frost, M.D., 960 41st Street, #402, Miami Beach

Spring Meeting of the Central Florida Society of Ophthalmology, May 16-18, Lake Buena Vista (Walt Disney World). For information: James A. Stokes, M.D., 55 W. Miller St., Orlando 32806

Twenty Sixth Annual Seminar of the Greater Miami Pediatric Society, May 21-22, Mailman Center for Child Development, Miami. For information: Stanley D. Rosenthal, M.D., 3700 N.W. 167th St., Opa Locka, Florida 33054.

Endometrial Carcinoma, May 28, Polk General Hospital, Bartow*

Cancer of the Colon, May 31, Ft. Pierce Memorial Hospital, Ft. Pierce*

JUNE

9th Annual Workshop in Electrocardiography, June 12-17, Sheraton Sand Key Hotel, Clearwater Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg

Cancer Prevention, Detection and Diagnosis, June 13, Auditorium, Brevard County Health Department, Rockledge*

Rehabilitation Needs of the Cancer Patient, June 16, Broward General Medical Center, Fort Lauderdale*

26th Annual Scientific Assembly, Florida Academy of Family Physicians, June 18-22, The Breakers Hotel, Palm Beach. For information: Dick L. VanEldik, M.D., 220 South Dixie, Lake Worth 33460

Current Approaches to the Clinical Problems of Cardiology in our Community, June 20-22, Sonesta Beach Hotel, Key Biscayne. For information: John W. Lister, M.D., 5080 Biscayne Blvd., Miami 33137

1975 Clinical Conference in Pre-Hospital Emergency Care, June 20-22, Orlando Hyatt House, Orlando. For information: Registrar, Pre-Hospital EMS Conference, 1919 Beachway Rd., Suite 5C, Jacksonville 32207.

JULY

▸International Doctors in Alcoholics Anonymous, July 31-Aug. 3, The Breakers Hotel, Palm Beach. For information: Lewis K. Reed, M.D., 1950 Volney Rd., Youngstown, Ohio 44511

AUGUST

Upper and Lower Extremity Prosthetics and Amputation, Aug. 6-10, Miami*

▸National Medical Association, Aug. 10-15, Fontainebleau Hotel, Miami Beach. For information: E. Leon Cooper, M.D., 2109 "E" St., N.W., Washington, D.C. 20037

Platelet Function and Disorders, Aug. 13, Baptist Hospital, Pensacola. For information: Richard Lawrence. M.D., Baptist Hospital, 1000 West Moreno Street, Pensacola 32501

Adriatic Discovery Air-Sea Cruise, Aug. 23-Sept. 5, departing Miami and Jacksonville. For information: Woman's Auxiliary, Florida Medical Association, P.O. Box 2411, Jacksonville 32203

SEPTEMBER

Hand Surgery, Sept. 19-21, Miami*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▸ National meetings being held in Florida.

Medical News Around the State

FLORIDA SOCIETY OF DERMATOLOGY . . . is accepting "Physician Wanted," "Situation Wanted" and "Practice Available" ads for its quarterly newsletter. The service is free of charge and available to board eligible and board certified dermatologists. Contact: Bernard H. Cohen, M.D., Florida Society of Dermatology, 9065 S.W. 87 Avenue, Miami, Fla. 33176.

21ST ANNUAL SOUTHERN OB.-GYN. SEMINAR . . . will be conducted at the Smoky Mountain Hilton at Asheville, N.C., July 21-25. Information may be obtained from George T. Schneider, M.D., Ochsner Clinic, 1514 Jefferson Highway, New Orleans, La.

HENRY R. COOPER, M.D., OF FT. LAUDERDALE has been named to the Board of Governors of the 6,000-member American College of Cardiology.

DCMA ADVISES—CUT WAITING TIME . . . Prolonged waiting time in doctors' offices generates considerable ill will among patients, the Dade County Medical Association says.

The Association's Public Service Committee noted that all doctors have occasional emergencies that take them off schedule, but "there are certain physicians whose patients apparently always have to wait for one or more hours."

The Committee called upon DCMA members to "remove this source of irritation from the community."

AMERICAN BOARD OF FAMILY PRACTICE . . . will administer its first recertification examination in five cities on October 29, 1976. Those physicians first certified in 1970 will take a half-day written examination and answer questions about 20 patient charts. Recertification fee will be $150. Additional information may be obtained from the American Board of Family Practice, University of Kentucky Medical Center, Annex 2, Room 229, Lexington, Ky. 49506.

PRESIDENT INSTALLED . . . Sorrel S. Resnik, M.D., Miami, Clinical Assistant Professor of Dermatology at the University of Miami School of Medicine, has been installed as President of the American Society for Dermatologic Surgery, Inc.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

udies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended

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Time to relax with your family — and still enjoy the professional advantages of modern facilities and a highly trained technical staff. You'll have the standing of an officer AND a professional. Yet, there's challenge, too. Air Force medicine ranges from research to every conceivable type of clinical practice, in every conceivable location you can imagine. Off-duty, you and your family can enjoy the excellent recreational facilities of the Air Force Base of your choice. Free travel. One month's paid vacation every year. And many other extras.

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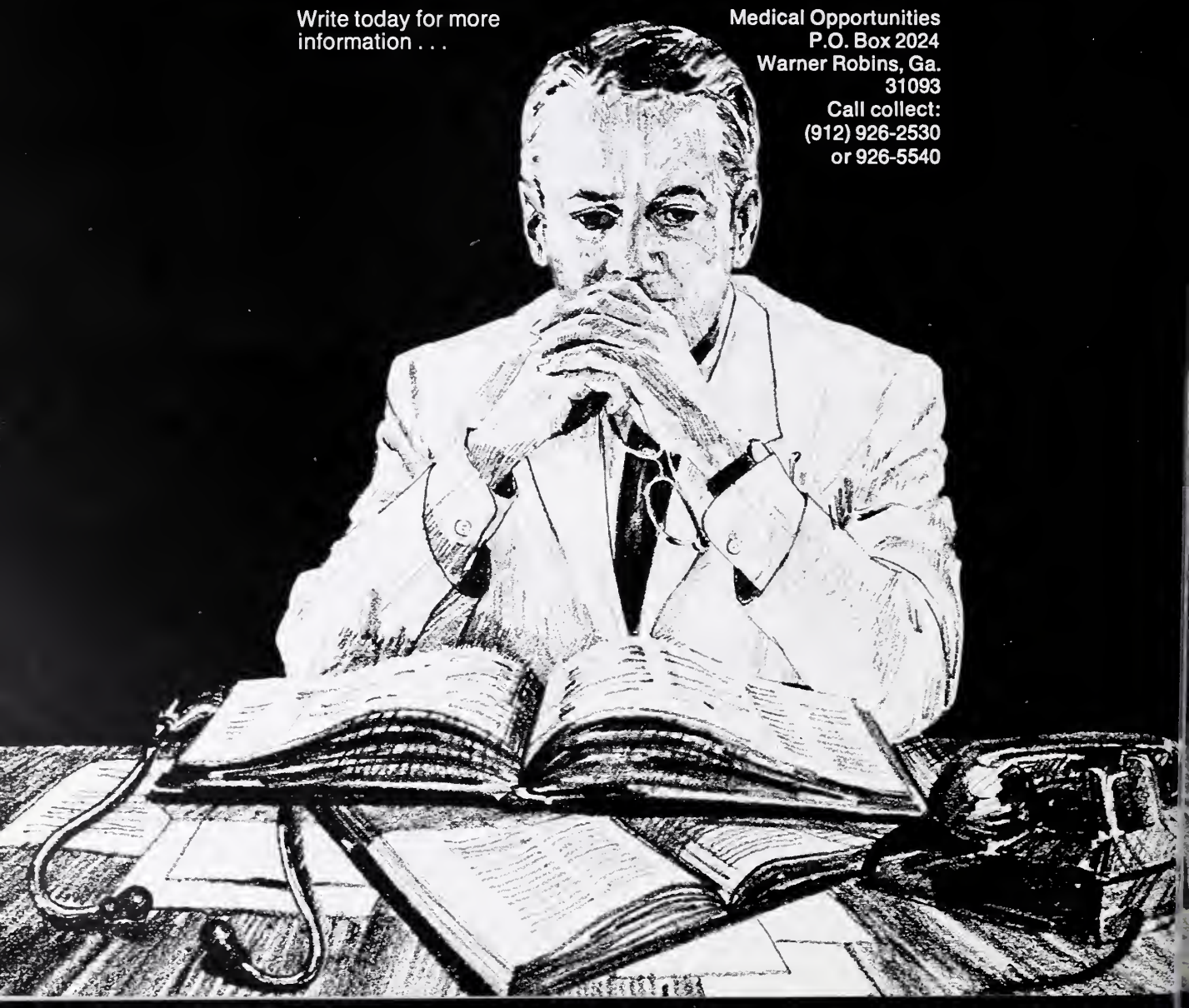
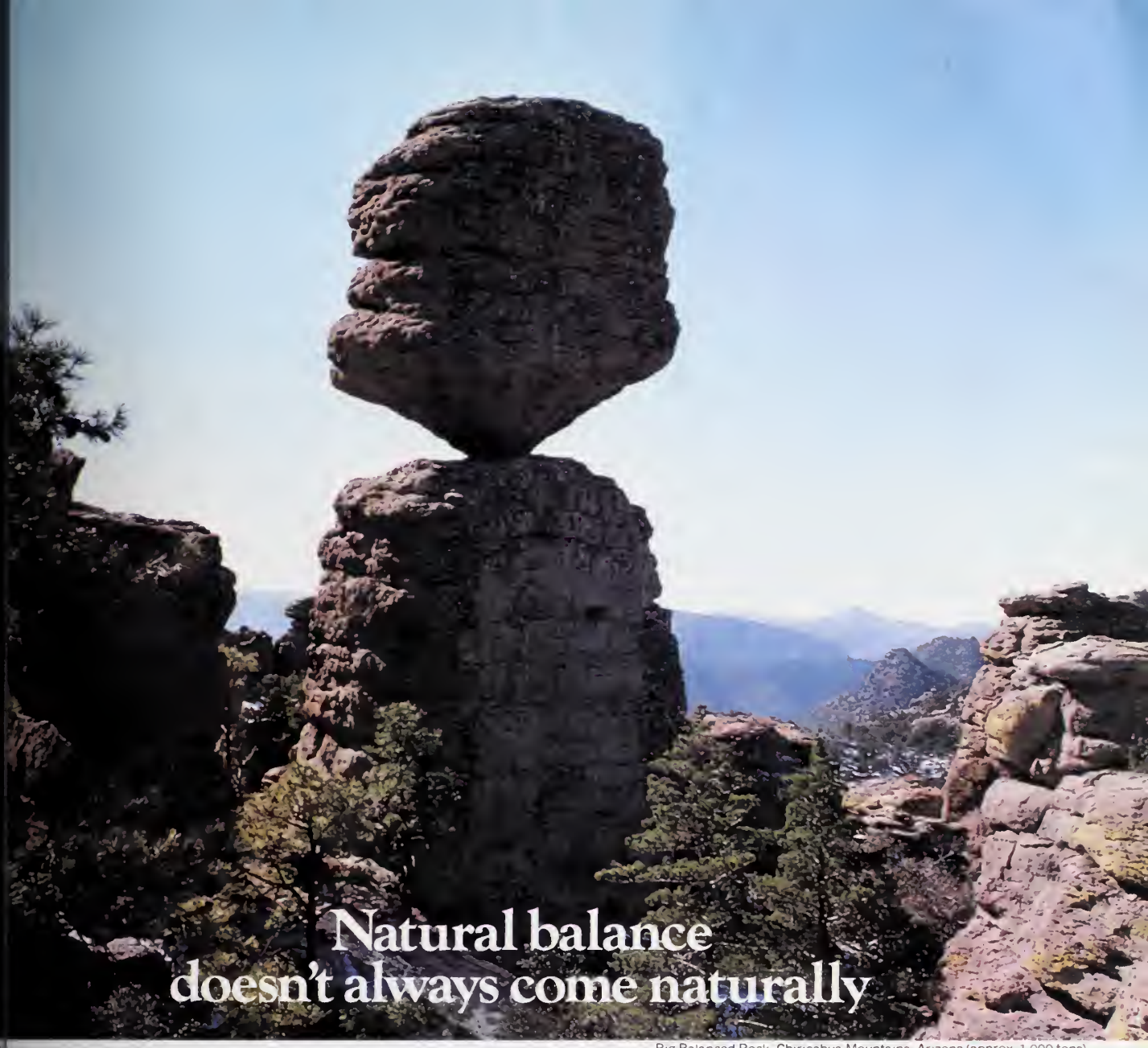




Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

und useful in the management of vertigo* associated with
ses affecting the vestibular system.
an relieve nausea and vomiting often associated with vertigo.*
sual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
so available as Antivert (meclizine HCl) 12.5 mg. scored
ts, for dosage convenience and flexibility.
ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for
ea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

DICATIONS. Based on a review of this drug by the National Academy of nces – National Research Council and/or other information, FDA has classified indications as follows:
ffective: Management of nausea and vomiting and dizziness associated with tion sickness.
ossibly Effective: Management of vertigo associated with diseases affecting the ibular system.
nal classification of the less than effective indications requires further estigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

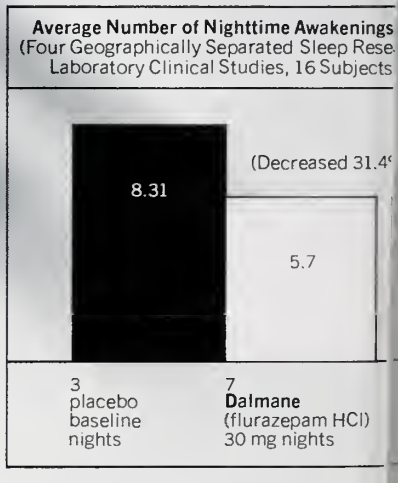
ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Would sleep with fewer nighttime awakenings benefit your patients with insomnia?

Highly predictable results for your patients with trouble staying asleep...

...can be obtained with Dalma (flurazepam HCl). As shown below, Dalmane significantly reduces nighttime awakenings:[1]



And for those with trouble ing asleep or sleeping g enough...

. Dalmane (flurazepam HCl) delivers excellent results. nically proven in sleep research oratory studies: on average, p within 17 minutes that lasts 8 hours.[5]

Dalmane (flurazepam HCl) elatively safe, seldom ises morning "hang-over"...

...and is well tolerated. The ial adult dosage is 30 mg *h.s.*, with elderly and debilitated ients, limit the initial dose to mg to preclude oversedation, ziness or ataxia. Evaluation of sible risks is advised before scribing.

FERENCES:

aracan I, Williams RL, Smith JR: The p laboratory in the investigation of sleep sleep disturbances. Scientific exhibit at 124th annual meeting of the American chiatric Association, Washington DC, 3-7, 1971

rost JD Jr: A system for automatically lyzing sleep. Scientific exhibit at the annual Clinical Convention of the erican Medical Association, Boston, 29-Dec 2, 1970; and at the 42nd annual ntific meeting of the Aerospace Medical ociation, Houston, Apr 26-29, 1971

Vogel GW: Data on file, Medical Depart-nt, Hoffmann-La Roche Inc., Nutley NJ

Dement WC: Data on file, Medical Depart-nt, Hoffmann-La Roche Inc., Nutley NJ

Data on file, Medical Department. ffmann-La Roche Inc., Nutley NJ

ore prescribing Dalmane (flurazepam l), please consult complete product ormation, a summary of which follows:

ications: Effective in all types of insomnia racterized by difficulty in falling asleep, quent nocturnal awakenings and/or early rning awakening; in patients with recurring omnia or poor sleeping habits; and in te or chronic medical situations requiring tful sleep. Since insomnia is often transient d intermittent, prolonged administration is erally not necessary or recommended.

ntraindications: Known hypersensitivity lurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Depend on highly predictable results with

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

specifically indicated for insomnia

Objectively proved in the sleep research laboratory:
- **sleep with fewer nighttime awakenings**
- **sleep within 17 minutes, on average**
- **sleep for 7 to 8 hours, on average,**

with a single *h.s.* dose.

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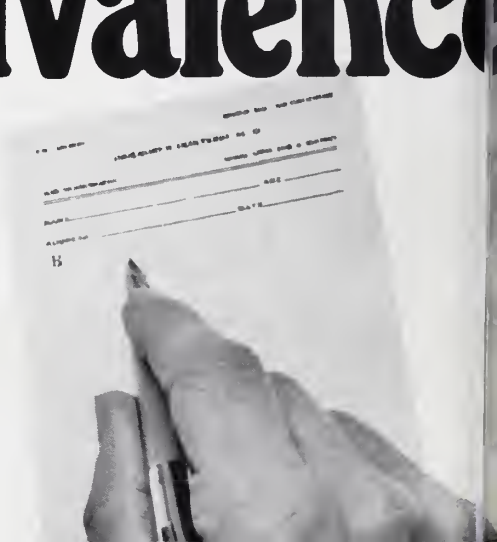
Bioequivalenc



the weight of scientific opinion:

If the pharmacist substituted a hemically equivalent drug for the ne you have specified for your atient—could you be certain of that roduct's safety and effectiveness imply because the chemical content vas the same?

Definitely not, unless bio- quivalence tests and other quality ssurance checks had been conducted. The pharmaceutical industry and nany scientists have maintained this osition for years, but others have uestioned it. Now the Office of echnology Assessment of the ongress of the United States has eported on the issue in its Drug ioequivalence Study.*

Here are a few definitive state- ments in the O.T.A. report:

"...the problem of bioinequiva- ency in chemically equivalent prod- cts is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compen- dial standards, these documented in- stances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug prod- ucts are, in fact, equivalent in bio- availability.

"While these therapeutic fail- ures resulting from problems of bio- availability were recognized and well documented, it is entirely possi- ble that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufac- turers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical prod- ucts, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual in- spections and certification thereafter, and strict adherence to FDA regula- tions on good manufacturing practices.

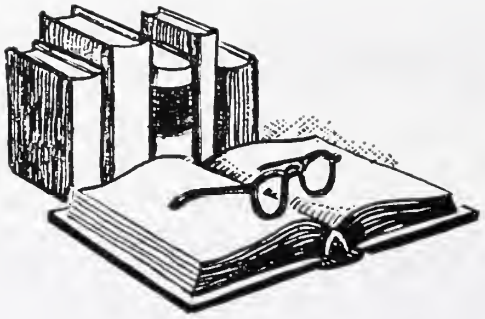
The overall quality of the United States drug supply is excel- lent. But only a total quality assur- ance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription



Book Reviews

The Dangerous Sky: A History of Aviation Medicine by Douglas H. Robinson, M.D. 279 Pages. Illustrated. Price $15.00. Seattle, University of Washington Press, 1974.

This volume by a physician flyer will interest aviation enthusiasts whether they be laymen, professional aviation personnel or physicians oriented toward aerospace medicine. Beginning with a chapter on balloon ascents and the medical problems encountered, the author proceeds to a detailed account of the development of heavier-than-air machines from the earliest attempts through and including supersonic aircraft. Flights to outer space are not within the province of this book. With each advance in power plant and aircraft design he discusses the medical problems presented and the attempted solutions. Finally, there are comments concerning the development of: armed forces and civilian aeromedical departments; problems peculiar to flying personnel, ground personnel and civilian passengers; and a rapid survey of the growth of worldwide civilian air transport. The book contains the dates and details of many "firsts" in aerospace medicine and will thus serve in a reference capacity. Generally the author holds the reader's interest with graphic eyewitness accounts of aerial problems and catastrophes. However, the physician reader may well wish there were less preoccupation with details of power plant and aircraft design which often make "the story" drag.

William M. Straight, M.D.
Miami

Practical Nuclear Medicine edited by Fuad S. Ashkar, M.D. 218 Pages. Price $25.00. New York, Medcom Press, 1974.

Prominently displayed on the office wall of an internist colleague of mine is a certificate from the Oak Ridge Institute of Nuclear Studies as a "Dabbler In Nuclear Medicine." As methods of diagnosis become more complicated and sophisticated, I think all of us using isotope procedures who are not fulltime nuclear medicine specialists tend to fall into this category. The days when a thyroid uptake probe, a wellcounter and a 3" rectilinear scanner constituted a nuclear medicine department, are long gone—in progress if not in actual years. This book can bring you up to date on what's happening in nuclear medicine and is one of the few not already out of date at the time of publication.

In the first three chapters, there are general discussions of current nuclear instrumentation, the clinical radiopharmaceuticals and the use of a computer in the presentation and interpretation of data. Nine chapters deal with anatomic regions and organ systems and the next three with topics of tumor localization, human tumor antigens and radioimmunoassay. The last chapter deals with radioisotope therapy. This is followed by a glossary and a 13 page, 200 question quiz with answers kindly provided at the end of the section. The book is very easy to read and despite multiple authors, all but one of whom is associated with the University of Miami, there is fairly good uniformity of chapter organization and excellent clarity of writing. Almost all of the tables and the math are relegated to the appendix, readily available but not intruding on the text. Brief "pearls," some more valuable than others, are sprinkled through the text, set aside in neat boxes.

The nuclear specialist might disagree with some of the points of view expressed, as alternative opinions are not usually mentioned, but references are provided in each chapter. This book is not for him but for the rest of us who depend upon him for sophisticated diagnostic and therapeutic techniques. Virtually all aspects of imaging, non-imaging and in vitro procedures are outlined and correlations with other methods of diagnostic studies are stressed.

This book will not make you an expert on scan interpretation (the illustrations are small and the half-tones of only fair quality) but what is much more important, this book tells you what you can expect from a nuclear diagnostic or therapeutic procedure as well as what you should not.

Lawrence H. Jacobson, M.D.
Miami Beach

Two Essays on the Mind by Benjamin Rush, M.D. with introduction by Erict Carlson. 120 Pages. Price $6.00. New York, Brunner/Mazel, 1972.

Why include two historical essays in a state medical journal? Benjamin Rush—physician, teacher, lecturer, and signer of the Declaration of Independence—is remembered for these accomplishments as well as being considered the father of American psychiatry. He is also remembered as being responsible for many deaths during the yellow fever epidemic in Philadelphia because of his zeal for bleeding and purging.

The first essay is entitled An Inquiry into the Influence of Physical Causes on the Moral Faculty, an oration delivered before the American Philosophical Society, 1786.

In these days of Watergate and the resignation of the Vice-President, his remarks are still applicable ". . . . it is absolutely necessary that our government, which unites into one all the minds of the states, should possess, in an imminent degree, not only the understanding, the passions, and the will, but above all, the moral faculty, and the conscience of an individual.—Nothing can be politically right, that is morally wrong; and no necessity can ever sanctify a law, that is contrary to equity. VIRTUE is the living principle of a republic. To promote this, laws for the suppression of vice and immorality will be as ineffectual, as the encrease and enlargement of gaols."

F. Norman Vickers, M.D.
Pensacola

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Symposium on Reconstruction of the Auricle by Radford C. Tanzer, M.D. and Milton T. Edgerton, M.D. 312 Pages. 611 Illustrations. Price $42.50. St. Louis, The C. V. Mosby Company, 1974.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D. 640 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1974.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Birth Defects, edited by Arno G. Motulsky and W. Lenz. 373 Pages. Illustrated. Amsterdam, Excerpta Medica, 1974.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 721 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Psychiatry in Primary Care by Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 Pages. Price $12.95. St. Louis, The C. V. Mosby Company, 1974.

Lifesaving, Rescue, and Water Safety by The American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Garden City, New York, Doubleday and Company, Inc., 1974.

In Defense of the Body by Roger Lewin. 146 Pages. Illustrated. Price $2.50. Garden City, New York, Anchor Press/Doubleday, 1974.

Clinical Perinatology edited by Silvio Aladjem, M.D. and Audrey K. Brown, M.D. 492 Pages. 135 Illustrations. Price $41.50. St. Louis, The C. V. Mosby Company, 1974.

The Malnourished Mind by Elie A. Shneour. 209 Pages. Illustrated. Price $2.95. New York, Anchor Press/Doubleday, 1975.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

The Dissector's Guide: A Detailed Investigation of Musculoskeletal Anatomy by Claudette Finley, M.S., R.P.T. 159 Pages. Illustrated. Price $11.95. Springfield, Ill., Charles C. Thomas, Publisher, 1975.

Mental Retardation by editors: Julius B. Richmond, M.D., Chairman; George Tarjan, M.D.; Robert S. Mendelsohn, M.D. 134 Pages. Price $2.00. Chicago, American Medical Association, 1974.

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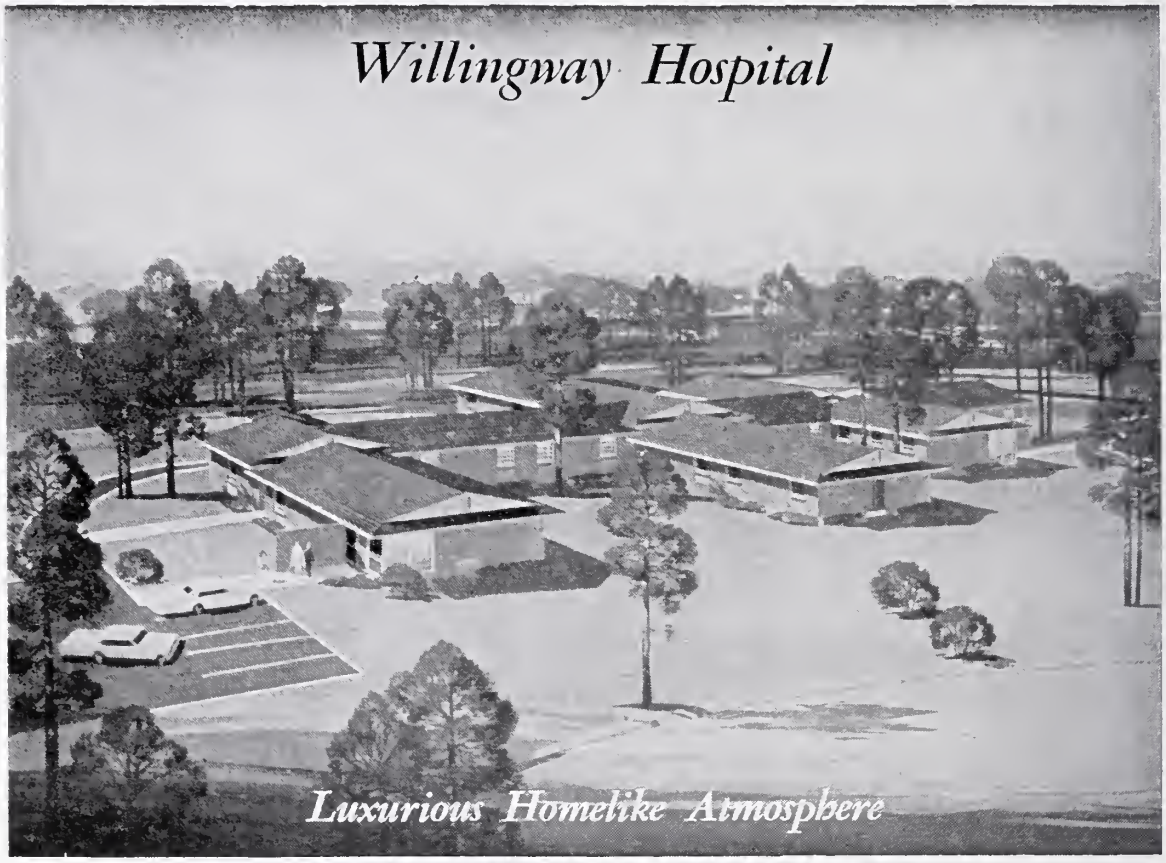

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1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

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1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

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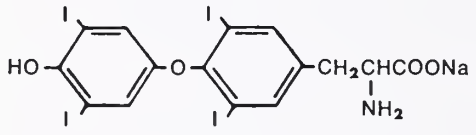
Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets,** taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets,** the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual

precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

Supplied:

Oral: Librium® (chlordiazepoxide HCl) *Capsules*—5 mg, 10 mg, 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

Libritabs® (chlordiazepoxide) *Tablets*—5 mg, 10 mg and 25 mg—bottles of 100 and 500.

Injectable: Librium® (chlordiazepoxide HCl) *Ampuls*—Duplex package consisting of a 5-ml dry-filled ampul containing 100 mg chlordiazepoxide HCl in dry crystalline form, and a 2-ml ampul of Special Intramuscular Diluent (for I.M. administration). Before preparing solution for I.M. or I.V. administration, please consult package insert for instructions on preparation and administration of solutions. Boxes of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Librium®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Please see following page.

Disruptive anxiety usually meets its match here.

Nancy Clifford, Exchange Officer
The Francis A. Countway Library of Med.
10 Shattuck Street
Boston, Massachusetts 02115

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC. • JUNE 1975

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

JUN 17 1975

Ordered, Declared And Adjudged:

". . . the doctors who had professional liability insurance policies with Argonaut Insurance Company under the Florida Medical Association program, as of April 8, 1975, and . . . . not opted out . . . ., are entitled to the maintenance of their professional liability insurance in full force through December 31, 1975, . . . at the premium rates . . . of January 1, 1975 . . .

"Argonaut is . . . . permanently enjoined from canceling . . . any member . . . . for the failure to pay the additional premium . . . to be effective March 15, 1975 . . . such premium increases are hereby declared null and void.

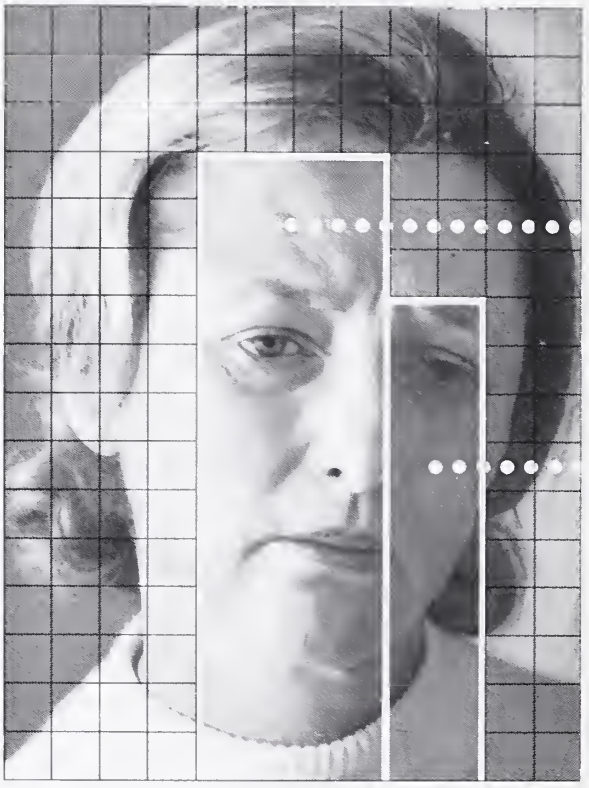
"Argonaut is . . . ordered to forthwith refund the additional premiums paid . . . on account of Argonaut's March 15, 1975, rate increase.

"The intervening physician class is . . . allowed to recover of the plaintiff, Argonaut Insurance Company, its costs of action."

—U.S. District Judge Gerald B. Tjoflat
in Final Judgment dated May 23, 1975

(For complete text of Final Judgment, see insert facing page 10)

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

THE FRANCIS A. COUNTWAY
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BOSTON

JUN 17 1975

According to her major
mptoms, she is a psychoneu-
tic patient with severe
ıxiety. But according to the
scription she gives of her
elings, part of the problem
ay sound like depression.
his is because her problem,
though primarily one of ex-
ssive anxiety, is often accom-
anied by depressive symptom-
ology. Valium (diazepam)
ın provide relief for both—as
ıe excessive anxiety is re-
eved, the depressive symp-
ms associated with it are also
ften relieved.

There are other advan-
ıges in using Valium for the
ıanagement of psychoneu-
otic anxiety with secondary
epressive symptoms: the
sychotherapeutic effect of
alium is pronounced and
apid. This means that im-
rovement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

urveillance because of their predisposi-
on to habituation and dependence. In
regnancy, lactation or women of child-
earing age, weigh potential benefit
gainst possible hazard.

recautions: If combined with other psy-
hotropics or anticonvulsants, consider
arefully pharmacology of agents em-
loyed; drugs such as phenothiazines,
arcotics, barbiturates, MAO inhibitors
nd other antidepressants may potentiate
s action. Usual precautions indicated in
atients severely depressed, or with latent
epression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

THE JOURNAL
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June Cover—1975 Florida Medical Association Board of Governors.

President's Page

"No Gnus is Bad Gnus"

The title of this page represents a poor pun but does serve to illustrate differences in understanding and communications. I might add that where physicians are concerned no news *is* bad news.

Communications are essential to our continued successful existence as human beings and particularly so as physicians. Two examples come to mind. In flying multi-engine aircraft, full power is commonly used during takeoff. This has been called "takeoff power." During the Korean conflict a four engine Air Force transport took off over Tokyo Bay and suddenly lost one engine while at low altitude. The captain, in trying to correct the dilemma, commanded the flight engineer with these words, "takeoff power!" Of course, you can envision the emergency and perhaps sympathize with the engineer who promptly cut all four throttles. One can also imagine the pilot's helplessness when, instead of feeling the expected surge of full throttle power in the remaining three engines, he became the pilot of an overloaded glider with the flight characteristics of a Mosler safe. At this altitude there was not sufficient time for further corrective communications and the plane crashed into the Bay with needless loss of life. The crash of an Eastern Airline L-1011 in the Everglades apparently resulted when a warning light indicated the nose wheel was not down. All flight officers became so engrossed in trying to correct the problem that they momentarily lost altitude and crashed. Lacking a sophisticated emergency communications network and disaster plan resulted in chaotic conditions. Ambulances and other emergency vehicles were stacked behind each other on one way car paths, unable to turn around or even reach the injured survivors.

Proper communications could have averted one of these disasters and greatly relieved the other. In a similar way we must improve our communications if we are to avoid disaster as physicians. Communications with the media, fellow doctors, other health providers, legislators, our wives, our receptionists, our nurses, and most of all, *our patients.*

How much we could improve our public image if we really told our story to the media. How many problems could be avoided between physicians if we only had the courtesy and thoughtfulness to speak to each other in common understanding ways. How much better our fellow health providers could carry out our orders and wishes if we took the time to explain the need for the procedure ordered, or the reason for urgency. How much easier for us to accomplish legislative assistance when our legislator has received personal communication *before* the final vote is taken and he comprehends fully our position and motives. How our home life might improve were we to take a moment and phone our wives explaining the reason for our delay and the new estimated time of arrival home. And lastly, how much more tolerant and understanding our patients become when someone takes a moment to explain why the doctor is late, or why their appointment is changed, or what the laboratory results or x-ray studies mean to them.

Communication is a tool we should use to sharpen our image.

Vernon B. Astler

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrog Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrog complex in the proportions foun in its natural source. And for mo than thirty years PREMARIN h enjoyed an unparalleled record clinical efficacy and acceptance.

PREMARIN. The only estroge preparation available that contai natural estrogens exclusively and meets all U.S.P. specifications fc conjugated estrogens. Assurance quality for you and your patient **PREMARIN . . . naturally.**

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

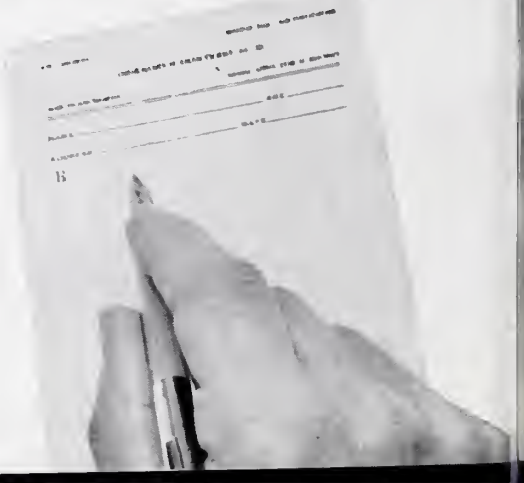
BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

Bioequivalence



he weight of scientific opinion:

If the pharmacist substituted a emically equivalent drug for the e you have specified for your tient—could you be certain of that oduct's safety and effectiveness mply because the chemical content as the same?

Definitely not, unless bio- uivalence tests and other quality surance checks had been conducted. he pharmaceutical industry and any scientists have maintained this sition for years, but others have estioned it. Now the Office of chnology Assessment of the ongress of the United States has ported on the issue in its Drug oequivalence Study.*

Here are a few definitive state- ents in the O.T.A. report:

"...the problem of bioinequiva- ncy in chemically equivalent prod- ts is a real one. Since the studies in hich lack of bioequivalence was monstrated involved marketed oducts that met current compen- al standards, these documented in- nces constitute unequivocal idence that neither the present ndards for testing the finished oduct nor the specifications for aterials, manufacturing process, d controls are adequate to ensure that ostensibly equivalent drug prod- ucts are, in fact, equivalent in bio- availability.

"While these therapeutic fail- ures resulting from problems of bio- availability were recognized and well documented, it is entirely possi- ble that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufac- turers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical prod- ucts, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual in- spections and certification thereafter, and strict adherence to FDA regula- tions on good manufacturing practices.

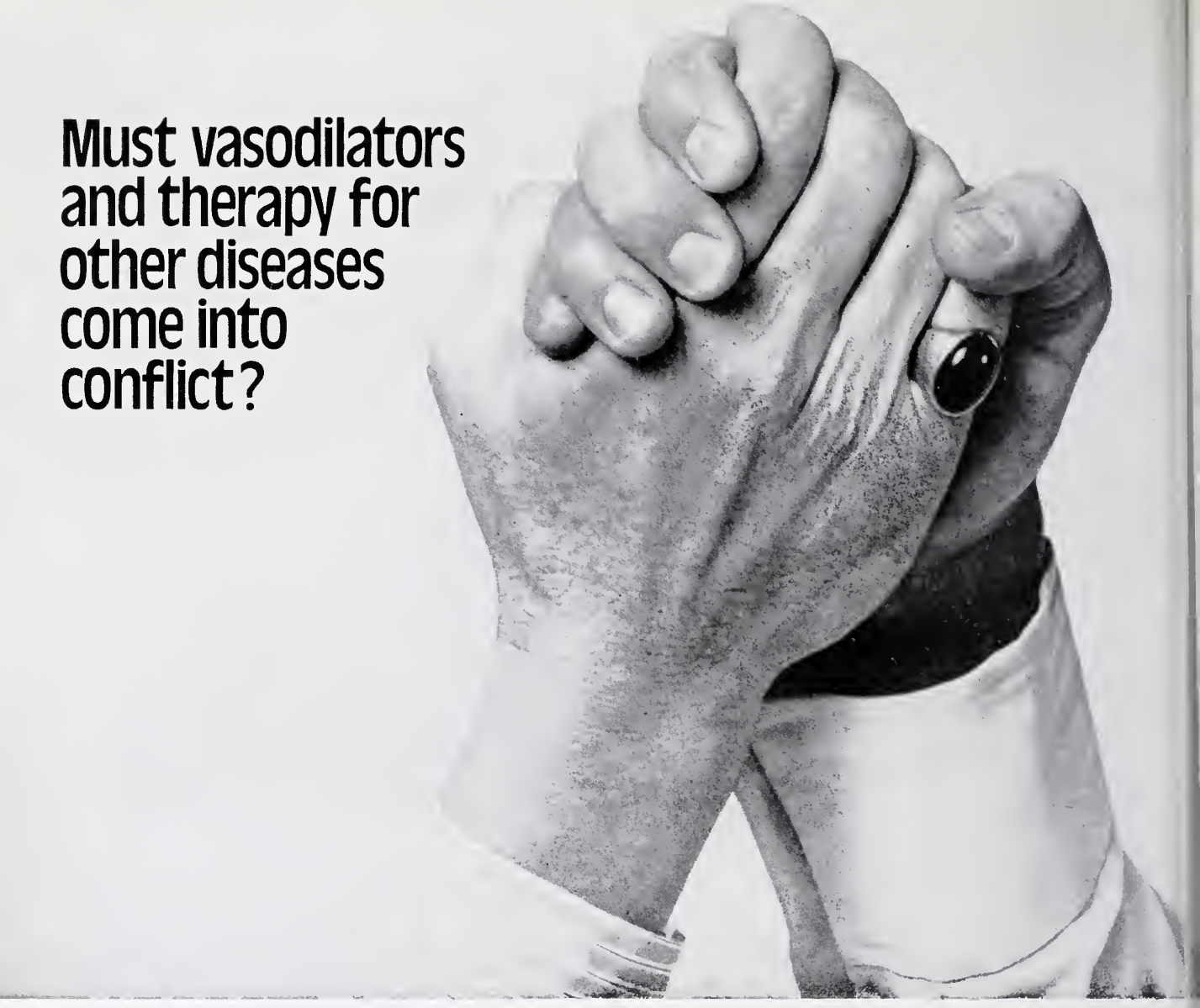
The overall quality of the United States drug supply is excel- lent. But only a total quality assur- ance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

rotecting the ntegrity of your prescription

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

United States District Court

MIDDLE DISTRICT OF FLORIDA

JACKSONVILLE DIVISION

ARGONAUT INSURANCE COMPANY,
a California corporation,
Plaintiff,

-vs-

FLORIDA MEDICAL ASSOCIATION, INC., a Florida corporation, FLAMEDCO, INC., a Florida corporation, HARLAN, INC. OF FLORIDA, a Florida corporation, and HARLAN-MED, INC., a Florida corporation,
Defendants,

No. 75-140 Civ-J-T

-and-

EMMET F. FERGUSON, JR., JOHN C. KRUSE and EDWARD J. SULLIVAN, in behalf of themselves and others similarly situated,
Intervenors.

FINAL JUDGMENT

This action came on to be tried before the court, and the court having made its findings of fact and conclusions of law in its orders of April 23, 1975 and May 19, 1975, it is hereby

ORDERED, DECLARED AND ADJUDGED:

1. The members of the intervening physician class, consisting of all of the doctors who had professional liability insurance policies with Argonaut Insurance Company under the Florida Medical Association program, as of April 8, 1975, and who have not opted out of the class, are entitled to the maintenance of their professional liability insurance in full force through December 31, 1975, but not thereafter, at the premium rates promulgated by Argonaut as of January 1, 1975, and Argonaut is hereby ordered to maintain such coverage during said time and at said rates.

2. Argonaut is hereby permanently enjoined from canceling the professional liability coverage of any member of the class for the failure to pay the additional premium promulgated by Argonaut to be effective March 15, 1975, and due April 1, 1975, and the endorsements relating to such premium increases are hereby declared null and void.

3. Argonaut is hereby ordered to forthwith refund and pay to all of the members of the intervening physician class the amounts of the additional premiums paid by such members of the class to Argonaut on account of Argonaut's March 15, 1975, rate increase.

4. Argonaut is hereby permanently enjoined from increasing or attempting to increase the premiums promulgated by Argonaut to be effective January 1, 1975, to the members of the intervening physician class for professional liability insurance during the calendar year 1975.

5. Argonaut is hereby ordered to rescind its Notice of Withdrawal From the Class of Malpractice Insurance in Florida, filed with the Florida Insurance Commissioner on April 16, 1975, insofar as the notice of withdrawal would in any way affect Argonaut's ability to fully provide the intervening physician class with professional liability coverage for the year 1975 in accordance with this final judgment.

6. Argonaut has no further obligation or responsibility to the Florida Medical Association to negotiate or issue new policies of professional liability insurance. Argonaut has no obligation to issue new policies of professional liability insurance to any member of the intervening physician class.

7. The intervening physician class is hereby allowed to recover of the plaintiff, Argonaut Insurance Company, its costs of action.

DONE AND ORDERED at Jacksonville, Florida, this 23rd day of May, A.D., 1975.

S/Gerald Bard Tjoflat

United States District Judge

Copies to all counsel

PRESIDENT'S Memo
FLORIDA MEDICAL ASSOCIATION
O. BOX 2411 • JACKSONVILLE, FLORIDA 32203

DATE: May 29, 1975

A-1

TO: Presidents, Component County Medical Societies

FROM: Vernon B. Astler, M.D., President

SUBJECT: Professional Liability Insurance

Each member of the Association has been advised of the order of the U.S. District Court which requires the Argonaut Insurance Company to continue in force those policies for insured physicians through December 31, 1975 at the premium rates which were negotiated and became effective January 1, 1975.

The membership has also been advised of the details of the Medical Malpractice Reform Act which became law on May 20, 1975. Its major provisions include a joint underwriting authority, a patient compensation fund, mandatory mediation panels, limiting the Statute of Limitations, informed consent and a Joint Study Commission which must submit recommendations to the Governor and the Legislature prior to January 1, 1976. This does not solve the entire problem, but it is a good beginning.

The leadership of the FMA is actively pursuing a major insurance carrier to underwrite the FMA sponsored plan. In the event this is not possible, the Association is also currently pursuing the details of a self-insurance trust to be implemented at an early date.

As President of your medical society, I would suggest that you urge your members to restrain from participating in unproven programs or schemes which are being promoted in various forms all over the State of Florida. During this transition period to a new carrier or insurance trust, physicians having difficulty obtaining liability coverage should contact Harlan-Med Insurance Agency, and they will attempt to search the current market and assist members in obtaining coverage with individual carriers if possible. The Harlan-Med toll free number is 1-800-342-8349 (P. O. Box 1319, Jacksonville, Florida 32201).

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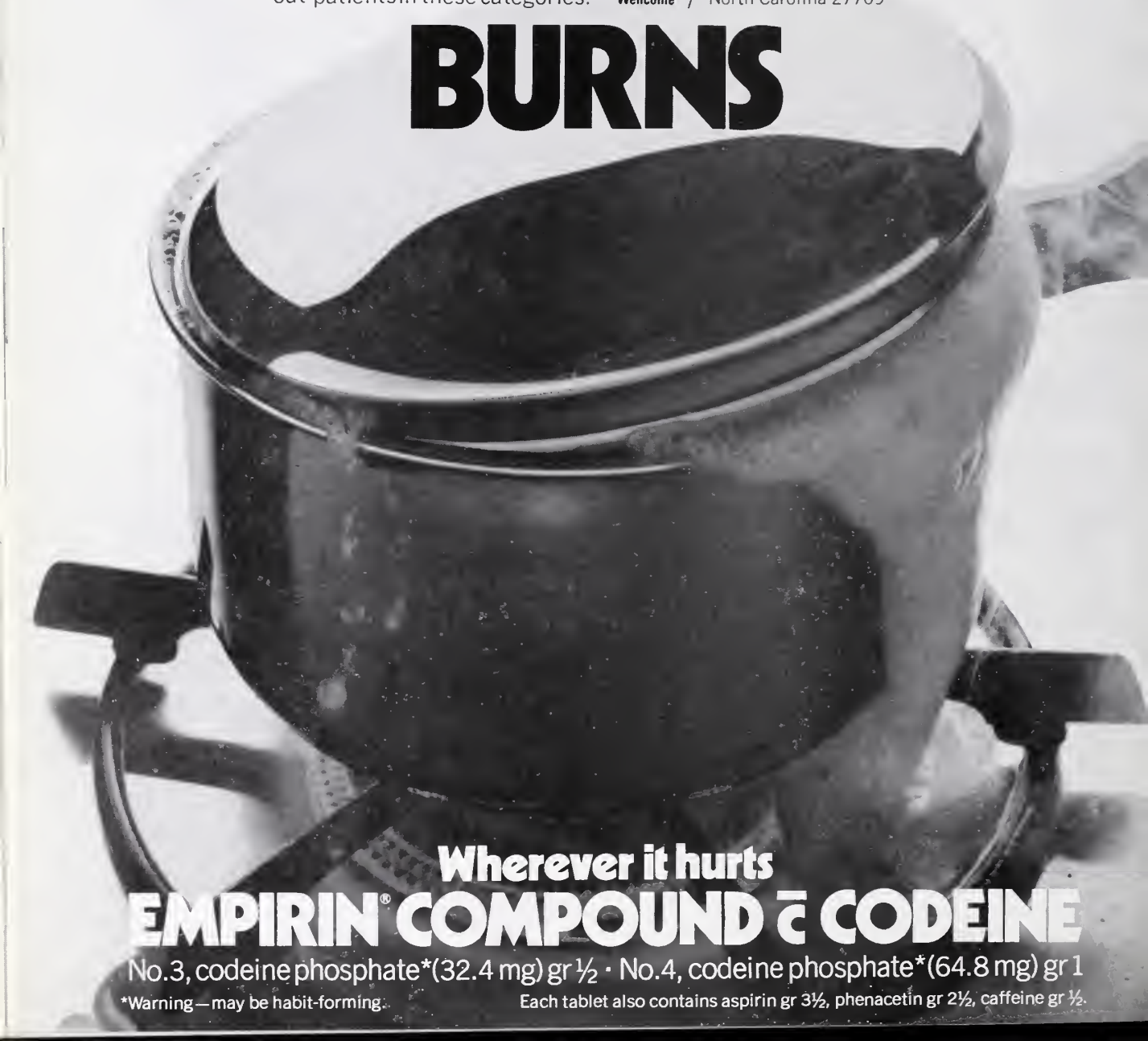

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

JUNE

Dissecting Aneurysm of the Aorta, June 4, Baptist Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Immunotherapy of Leukemia, Lymphoma and Associated Diseases, June 11, Victoria Hospital, Miami*

9th Annual Workshop in Electrocardiography, June 12-17, Sheraton Sand Key Hotel, Clearwater Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg

Cancer Prevention, Detection and Diagnosis, June 13, Auditorium, Brevard County Health Department, Rockledge*

Rehabilitation Needs of the Cancer Patient, June 16, Broward General Medical Center, Fort Lauderdale*

Courses of Instruction in Coronary Care for the Practicing Physician, June 16-21, Jackson Memorial Hospital, Miami*

26th Annual Scientific Assembly, Florida Academy of Family Physicians, June 18-22, The Breakers Hotel, Palm Beach. For information: Dick L. VanEldik, M.D., 220 South Dixie, Lake Worth 33460

Workup of a Patient with Lymphadenopathy, June 19, Mr. John's Steak House, Inverness*

Current Approaches to the Clinical Problems of Cardiology in our Community, June 20-22, Sonesta Beach Hotel, Key Biscayne. For information: John W. Lister, M.D., 5080 Biscayne Blvd., Miami 33137

1975 Clinical Conference in Pre-Hospital Emergency Care, June 20-22, Orlando Hyatt House, Orlando. For information: Registrar, Pre-Hospital EMS Conference, 1919 Beachway Rd., Suite 5C, Jacksonville 32207.

JULY

Courses in Instruction in Coronary Care for the Practicing Physician, July 21-26, Jackson Memorial Hospital, Miami*

▸International Doctors in Alcoholics Anonymous, July 31-Aug. 3, The Breakers Hotel, Palm Beach. For information: Lewis K. Reed, M.D., 1950 Volney Rd., Youngstown, Ohio 44511

AUGUST

Upper and Lower Extremity Prosthetics and Amputation, Aug. 6-10, Miami*

▸National Medical Association, Aug. 10-15, Fontainebleau Hotel, Miami Beach. For information: E. Leon Cooper, M.D., 2109 "E" St., N.W., Washington, D.C. 20037

Courses of Instruction in Coronary Care for the Practicing Physician, August 11-16, Jackson Memorial Hospital, Miami*

Platelet Function and Disorders, Aug. 13, Baptist Hospital, Pensacola. For information: Richard Lawrence. M.D., Baptist Hospital, 1000 West Moreno Street, Pensacola 32501

Adriatic Discovery Air-Sea Cruise, Aug. 23-Sept. 5, departing Miami and Jacksonville. For information: Woman's Auxiliary, Florida Medical Association, P.O. Box 2411, Jacksonville 32203

SEPTEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 8-13, Jackson Memorial Hospital, Miami*

Florida Society of Anesthesiologists Annual Fall Meeting: Current Status of Inhalation Anesthetics, Sept. 13, Walt Disney World, Orlando. For information: Edwin S. Munson, M.D., Dept. of Anesthesiology, University of Florida, Box 721, J. Hillis Miller Health Center, Gainesville 32610

Teaching Conference in Pediatric Radiology, Sept. 17-21, Miami*

Tumor Immunology and Immunotherapy, Sept. 18, Mr. John's Steak House, Inverness*

Hand Surgery, Sept. 19-21, Miami*

Facts and Fantasies About Diverticular Disease of the Colon, Sept. 24, Sacred Heart Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 29-Oct. 4, Jackson Memorial Hospital, Miami*

OCTOBER

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33205

Internal Medicine for the Practicing Physician, Oct. 3-4, Perdido Country Club, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Symposium on Emergency Cardiology and Medical Services, Oct. 12-14, Orlando Hyatt House, Orlando**

Arthritis and Orthopaedics, Oct. 17-19, University of Miami, Miami*

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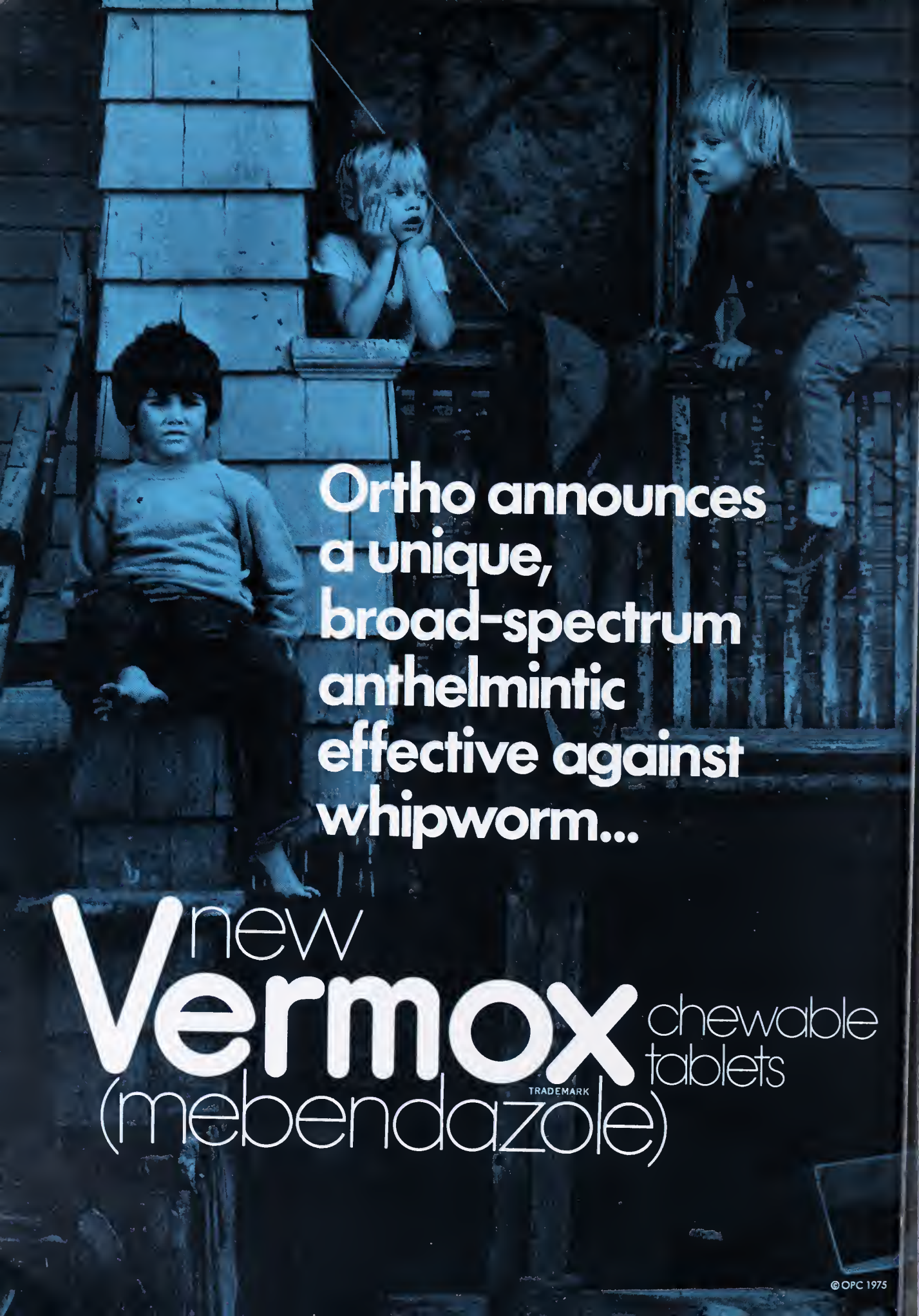
*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▸ National meetings being held in Florida.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Vermox
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chewable
tablets
(mebendazole)

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...and highly effective against roundworm, hookworm and pinworm in single or mixed infections

No dosage calculations — one simplified dosage, regardless of weight or age†

whipworm, roundworm, hookworm and mixed infections:
1 chewable tablet b.i.d. for 3 consecutive days

pinworm: 1 chewable tablet

If the patient is not cured three weeks after treatment, a second course of treatment is advised.

highly effective

	Mean cure rates	Mean egg reduction
Whipworm	68%	93%
Roundworm	98%	99.7%
Hookworm	96%	99.9%
Pinworm	95%	— — —

simplicity of administration patients can take the tablet at any time. It can be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

not a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

convenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

well tolerated transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

†Vermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Indications Vermox* (mebendazole) is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.

Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

Contraindications Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults.

For control of trichuriasis, ascariasis, and hookworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

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Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
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Potassium (from Potassium Sulfate)	2.5 mg.
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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE, 1975 • VOLUME 62 • NUMBER 6

The Neuro-Otologic Approach to the Dizzy Patient

FREDRIC W. PULLEN II, M.D. AND CONSTANCE H. CABEZA, M.A.

Abstract: In a patient with vertigo a complete history and physical examination including selective neural and otologic examinations should be performed. Medical treatment must be directed at the disease process and will include vasodilators in the case of vascular insufficiency and the use of anticoagulants if the symptoms warrant as well as vestibular suppressive agents, and metabolic control. If medical treatment fails and the patient has incapacitating vertiginous disease then the surgical approach is indicated.

Dizziness is one of the most commonly encountered symptoms in the practice of medicine. The frequency is second only to headache. Many patients complain of lightheadedness or dizziness which is not true vertigo but presents a complicated diagnostic problem. Most are treated symptomatically and the true cause of their difficulty rarely is diagnosed.

Dizziness or vertigo is often a sign of a disturbance in the vestibular system, including its relationship to the visual and proprioceptive systems. Careful attention to the symptomatology, scrupulous examination and review of all systems as well as the vestibular system aid in the diagnosis and enable the physician to treat his patients more intelligently.

A carefully taken history is the most essential part of obtaining a correct diagnosis. Symptoms such as hearing loss, tinnitus, a sense of fullness in the ear, otorrhea or otalgia, should be noted. Headache, nausea, vomiting, accompanying neurologic symptoms and blackouts are also significant. Drug ingestion should be inquired into and the presence of systemic diseases such as diabetes, hyperthyroidism, hypertension, and atherosclerosis should also be noted.

The type of dizziness should be characterized and a distinction drawn between true vertigo and a "sensation of dizziness." True vertigo is a sensation of movement, either of the individual himself or surrounding objects and may be accompanied by pallor, cold sweats, nausea and vomiting. Dizziness is distinguished by a feeling of lightheadedness or faintness and usually no sensation of motion is experienced.

If the patient is experiencing true vertigo, the lesion is considered to be close to the peripheral labyrinth. The patient with a central lesion frequently complains of dizziness and his symptoms are more prolonged than those associated with peripheral lesions. The peripheral vestibular system can become severely overtaxed when the labyrinths are functioning and the central pathways are interrupted.

True vertigo can assume many forms. It may be continuous, over varying periods of time and independent of head and body motion or positional occurring only when the head and body are in certain positions. It can be either transient or episodic, however, true vestibular vertigo rarely lasts longer than two to three weeks. Patients suffering sudden total loss of labyrinthine function may have severe vertigo which gradually subsides

Dr. Pullen is Associate Clinical Professor in the Department of Otolaryngology, University of Miami School of Medicine, and Mrs. Cabeza is director of the Miami Hearing and Speech Center, Miami.

after this time, however, it may become positional in type, persisting for longer periods.

Nausea and vomiting may accompany disorders of the labyrinth, whereas vomiting without nausea is usually indicative of central nervous system involvement. In patients having lesions within the posterior fossa, nausea and vomiting are usually absent unless there is brain stem involvement.

Ataxia in association with vertigo may be a sign of peripheral or cerebellar disease, but ataxia without vertigo usually does not indicate a disease of the labyrinth. Vertigo or dizziness of peripheral origin frequently is accompanied by otologic symptoms such as hearing loss, tinnitus, otalgia, or otorrhea. Neurological symptoms such as numbness in the hands and face, dysadiodochokinesis, dysmetria, asynergia, blindness, weakness or clumsiness, or dysphagia may accompany vertigo of central origin, rarely peripheral disease.

The Neuro-Otologic Examination

A complete ear, nose and throat examination should be performed on all patients with vertigo, particular attention being given to the middle ears and nasopharynx. The tympanic membranes must be inspected for evidence of disease, such as cholesteatoma or perforations. The neck should be examined for limitation of motion and palpated for any masses. The blood pressure should be taken in both arms and, in conjunction with this, auscultation performed on the skull and carotid areas to listen for bruits. A complete cranial nerve examination must be performed paying particular attention to the nerves in association with the eighth cranial nerve, e.g. V, VI, VII, IX, and X. A complete cerebellar and proprioceptive examination should also be performed, noting the presence of asynergia, dysmetria, dysadiodochokinesis, or abnormal rebound phenomena which usually indicates a disturbance in the cerebellar hemisphere on the side of the abnormality. A Romberg test should be performed and the patient's posture noted while sitting, standing and walking.

The most important part of the examination is the observation for nystagmus or rapid to and fro movements of the eyes, which should be looked for in all ocular positions.

Nystagmus with slow and fast components is considered to be vestibular in origin. If the movement is equal in both directions and pendular, the nystagmus is considered to be ocular. Vestibular nystagmus is usually horizonto-rotary in nature and is found in peripheral disease, whereas, vertical nystagmus is usually pathognomonic of a central lesion. In peripheral lesions spontaneous nystagmus is almost always direction constant and transient. In central lesions, spontaneous nystagmus is prolonged, direction changing and may not be accompanied by the sensation of vertigo.

Positional testing should always be performed on patients. Lesions of the vestibular labyrinth are ordinarily associated with a delay in the onset of the nystagmus on positional testing. The symptoms are frequently less than 60 seconds in duration, are fatigable, and the reaction cannot be elicited after the test has been repeated several times. With central lesions, however, the onset of nystagmus is immediate, the duration is long and not fatigable. Immediate nystagmus and the nystagmus retractorius in the absence of vertigo suggests involvement of the fourth ventricle with secondary vestibular nuclei irritation. Vestibular labyrinthine function should be evaluated and the simplest means is the cold water caloric test; the most important factor being the equality of function between the two sides. Hypoactive responses may be obtained in certain diseases whereas a completely normal response found in others. One easy method of performing the caloric test is to fill the ear with ice water and allow it to remain for 20 seconds with the patient's head tipped backwards 30 degrees. The water is then drained from the ear and the onset and duration of nystagmus is noted. The other ear then undergoes the same test and a comparison of reactions made. This is much less traumatic than injecting 10 cc. of ice water into the ear of an already nervous patient.

A direct observation can be made following hot or cold calorics with Frenzel's glasses, however, electronystagmography (ENG) is a better method of recording and provides a permanent record. The ENG has the following advantages: ease, repeatability, accuracy, reduction of artifacts and smaller differences between the vestibular systems can be detected.

Electrodes are used to measure ocular nystagmus. The significant factors measured are the maximum frequency, average speed of slow component in degrees per second, (the actual labyrinthine reflex), and duration of nystagmus.

In peripheral disease the direction of nystagmoid movements is always predictable following

caloric stimulation, however, with central lesions stimulation may produce a perverted nystagmus in any direction.

Every patient with suspected vestibulocochlear eighth nerve disease must have a complete audiologic evaluation. This includes pure tone air and bone conduction thresholds, speech reception thresholds, speech discrimination testing for phonetically balanced words, tests for recruitment, Bekesy testing for fatigue of the eighth nerve, and impedence testing with stapedius reflex and decay as well as a tympanogram. These tests usually determine whether a lesion is cochlear, retrocochlear, or more centrally located.

Hearing losses are usually placed in four classifications (Table 1). Conductive losses are caused by an impairment in the conduction mechanism of the external or middle ear and are rarely associated with vertigo. Sensory deficits are caused by a decrease in the number of hair cells in the cochlea. Neural or retrocochlear losses are caused by a decrease in the neural elements between the cochlea and cochlear nuclei. Central disorders are caused by a lesion in the central pathways.

Audiological findings of retrocochlear lesions may not fit any conventional pattern early in their growth. Since a lesion may cause compression of the arteriovenous system, cochlear signs may be present and tone decay as well as reflexes may not be abnormal.

Disease and treatment of the vestibular system may be best divided by location and etiology.

End Organ Disease

I. Meniere's Disease (Endolymphatic Hydrops)

This is a waste basket diagnosis frequently applied in any patient with dizziness, tinnitus and hearing loss. The specific Meniere's syndrome is constituted by vertigo of several minutes to several hours duration accompanied by a fluctuant hearing loss and tinnitus. In the early course of the disease there is improvement in hearing following attacks, and attacks are episodic. Caloric examination shows hypoactivity or normal activity. The triad of symptoms is necessary for this diagnosis to be made, and they are usually considered to be due to an increase in endolymph pressure within the ear.

Treatment is directed at reducing endolymphatic pressure by either any of or a combination of low sodium diet, vasodilators, diuretics and vestibular suppressants. If medical treatment is unsuccessful and the patient continues with intractable vertiginous attacks, surgical intervention is indicated. Surgery includes opening the endolymphatic duct by providing a fistula or shunt and may be accomplished by any one of these conservative procedures: 1. Endolymphatic Sac Decompression, 2. Endolymphatic Shunt, 3. Sacculotomy, 4. Cody Tack, and 5. Cryotherapy (otic-perotic shunt).

Destructive procedures are limited only to those ears whose hearing need not be preserved and include 1. Transtympanic Labyrinthectomy, 2. Transmastoid Labyrinthectomy and Eighth Nerve Section, 3. Middle Fossa Superior and Interior Nerve Section, and 4. Ultrasonic Labyrinthectomy.

II. Toxic Labyrinthitis

This is one of the most common causes of a single attack of vertigo. The attack lasts a day or two and then gradually subsides, there is no associated deafness or tinnitus. Caloric tests are normal. The etiology is usually a toxic reaction due to an infection, drugs or allergy.

Treatment is directed at suppression of the abnormal vestibular reflexes by either potent antihistamines or other CNS suppressants such as dimenhydrinate, meclizine hydrochloride, diphenidol, trimethobenzamide, prochlorperazine, chlorpromazine, diazepam, thiethylperazine, and barbiturates.

III. Viral Labyrinthitis

There is a sudden partial or total loss of hearing as well as an acute attack of vertigo, which is usually accompanied by tinnitus. The vertigo lasts for a period of days or weeks and gradually improves. Recovery may be partial or complete but attacks may recur following the doctrine of *placum locus minoris.*

IV. Benign Positional Vertigo

These vertiginous episodes occur during movement in certain positions. There is usually no hearing loss or tinnitus and no spontaneous nystagmus. On positional testing the patient experiences vertigo, and nystagmus is seen after a delay of two to ten seconds. This type of nystagmus usually lasts under two minutes, is usually fixed in direction, and is not reproducible more than two or three times. Caloric tests are normal. The etiology is unknown in over half the cases, but trauma and viral diseases have been incriminated as well as cupulolithiasis. The disease will gradually subside after a period of time, however, recurrences are common but limited.

Treatment is usually symptomatic with vestibular suppressants and neck exercises.

V. Sudden Sensorineural Deafness

This condition may result from vascular occlusion, hemorrhage into the inner ear, fractures of the temporal

Table 1.—Summary of Audiological Findings for Normal Hearing and for Hearing Losses.

	Normal	Conductive	Sensory	Retrocochlear	Central
Loss of Pure Tones	No	Yes	Yes	Yes	No
Air-Bone Gap	No	Yes	No	No	No
Speech Discrimination	92-100%	92-100%	Decreased	Very Poor	92-100%
Bekesy Type	I	I	II, IV	III, IV	I
SISI	0-20%	0-20%	80-100%	0-20%	0-20%
ABLB (recruitment)	No	No	Yes	No	No
Tympanogram	Normal	Abnormal	Normal	Normal	Normal
Stapedius Reflex	Present	±	±	Absent	Present
Stapedius Reflex Decay	None	None	None	Present	None

bone, suppurative or viral labyrinthitis, and acute rupture of the round or oval windows. The patient may suddenly experience total deafness and a loss of vestibular function on the side of the involvement. Severe vertigo may result which subsides after several weeks. Treatment directed at the etiology may be suppressive or surgical.

VI. Otitis Media: Acute or Chronic

Infections may give rise to vertiginous episodes secondary to serous or suppurative labyrinthitis of the toxic type. A fistula may also develop into the vestibular labyrinth which can give rise to repeated episodes of vertigo of short duration. The fistula test is elicited by putting positive pressure into the ear canal through a closed otoscope and observing the eyes for nystagmus. A positive fistula test is said to occur when nystagmus is noted secondary to this pressure in the ear. Treatment is almost always surgical to eradicate infection and to restore hearing.

Retrocochlear or Eighth Nerve Lesions

I. Acoustic Neuroma

The vertigo first noted is mild and may include some ataxia. Severe loss of speech discrimination is usually found with the pure-tone average gradually declining. The presence of stapedius reflex decay is extremely important as well. In 95% of the tumors there is a hypoactivity of the vestibular system to caloric stimulation. Positional nystagmus may also be present early in the disease. When the tumor gets larger, there are involvements of either cranial nerves, V, VII, IX or X as well as cerebellar signs. Increased cerebrospinal fluid pressure may be found and an increase in CSF protein later in the disease. EEGs and brain scans are usually useless in posterior fossa tumors but polytome x-rays of the internal auditory meatus as well as pantopaque myelography studies should be made on any patient with suspected tumors. In very suspicious cases an analysis of perilymph protein may be made through a stapes foot plate tap which will reveal an extremely high level.

With the newer methods of surgery available the morbidity and mortality rates are now approaching zero, while the preservation of hearing is accomplished at times in smaller tumors. It is very important to suspect a neuroma early and treat it early if one is to be successful in preserving other nerve functions.

II. Vestibular Neuronitis

This may also be an episodic disease with recurring episodes of vertigo for periods of several weeks to several months very similar to labyrinthitis. There is, however, no tinnitus or hearing loss. Spontaneous nystagmus is seen in the presence of vertigo. There is usually a hypoactive caloric response on the side of the lesion, which is considered by some to be an isolated arachnoiditis.

The treatment is again aimed at suppression of the abnormal vestibular responses. Steroids have been used to decrease inflammation and decompression of the internal auditory meatus has also been shown to be of value in chronic cases.

Symptoms of Bell's palsy and hearing loss are usually due to herpetic involvement of the geniculate ganglion and labyrinth and symptoms of vertigo, hearing loss and tinnitus are associated with the typical herpetic eruption in the external auditory canal. Pain in the ear canal is usually the primary symptom. Medical treatment is supportive with vestibular suppressants, however, hearing rarely is recovered. The facial nerve paralysis, if it does not recover with medical treatment of steroids and vasodilators or shows fibrillation potentials, should be surgically decompressed from the geniculate ganglion peripherally to the stylomastoil foramen. This may entail two surgical approaches, through the middle cranial fossa or through the mastoid as well. Facial recovery is usually found even it surgery is performed three or four months after the onset of the disease.

Central Lesions

I. Meningitis, Encephalitis

The patient may have a mild degree of dizziness, however, hearing and vestibular function are normal. Treatment is directed at the etiologic agents.

II. Brain Stem Lesions

Vertigo or dizziness may accompany lesions of the brain stem, however, neurologic examination frequently reveals an involvement of other cranial nerves. Vertical nystagmus is usually pathonomonic of central lesions, and may also be an indication of drug toxicity, since central effect is common. Multiple sclerosis usually is recognized by recurrent exacerbations and may show a characteristic pattern on electronystagmography.

III. Positional Vertigo of the Central Type

Patients upon turning in specific positions note the onset of immediate vertigo (with nystagmus which is continuous as long as the position is maintained and is characteristic of central disease). The nystagmus is not always fixed in direction. Caloric test responses are usually normal as is the hearing. With the newer brain scanning instrumentation available such as the coaxial tomography scanner, smaller tumors may more easily be found, with little patient risk.

IV. Cerebellar Lesions

Vertigo or dizziness found in lesions of the vermis will result in a loss of truncal equilibrium, poor posture, and a wide gait. Lesions of the cerebellar hemisphere result in poor motor coordination with asynergia, dysadiodochokinesis and dysmetria on the side of the lesion. Again ENG and CAT scanning are important tools in the diagnostic armamentarium.

V. Epilepsy

Dizziness is not uncommon in grand mal epilepsy, but is usually a part of the prodromal phase. Treatment is medical and usually successful.

Vascular Diseases

I. Hypertensive Cardiovascular Disease

Arteriosclerosis usually results in a decreased vascular supply to the internal auditory artery with resultant ischemic symptoms. These will be transitory and usually resolve themselves upon lying down. The symptoms may be due to occlusion of one of the major arteries affecting the vestibular system, e.g., the internal auditory artery with its divisions, vestibulocochlear or vestibular artery. With involvement of the posterior inferior cerebellar artery, the anterior inferior cerebellar artery or the basilar artery, there will be associative symptoms and signs of other nuclear involvement.

II. Cervical Vertigo

Dizziness may be present as a result of compression of vertebral or carotid arteries, or the sympathetic trunk, as with hyperextension of the neck and also secondary to cervical muscle spasm. These symptoms may be associated with pain in the neck as well as recurring episodes of vertigo. The hearing is usually normal as well as vestibular function. The symptoms of vertigo occur during positional testing but only when the neck is turned on the trunk.

Treatment is symptomatic and neck exercises by turning the head to place the chin on each shoulder has been found to be very helpful.

III. Migraine (Basilar Artery Migraine)

Migrainous attacks accompanied by vertigo, especially in instances of basilar artery migraine, are usually due to the prodromal vasoconstriction before the headache occurs. The history is the most important differential and should be followed carefully.

Treatment by vasodilators and the newer antiserotonin drugs is best and very satisfactory.

Systemic Diseases

I. Drug Ingestion

Dizziness is frequently found in persons taking drugs for the treatment of other systemic disorders. A common sign in patients who are taking barbiturates or sedatives is vertical nystagmus. Estrogens have also been incriminated, as well as antihistamines, antihypertensives, alcohol, meperidine, and other narcotics. It would be prudent to question very carefully every patient with vertigo to ascertain whether they are taking any drugs regularly.

II. Blood Disorders

Occasional vertigo is seen in the various anemia due to the hypoxia of the end organ.

III. Hypoglycemia

In certain instances of hypoglycemia, lightheadedness is described, accompanied by headache, sweating pallor, nausea and occasional vomiting. This is usually due to gluconeogenosis secondary to adrenalin release. Dietary control is almost always successful in treating this symptom.

IV. Allergy

There is a great amount of medical literature that has incriminated allergy as an etiologic agent of vertigo especially food allergies. The symptoms are often accompanied by gastric distress, periods of drowsiness after meals, occasional headaches, coughing episodes, itching and occasionally insomnia. The treatment obviously necessitates discerning the allergen and instituting the corrective process of either elimination or desensitization.

V. Psychophysiologic Reactions

Patients with emotional difficulties frequently complain of continuous dizziness or vertigo over long periods of time while other organic signs are completely absent. There is usually no evidence of nystagmus and all neuro-otologic testing is normal. This, too, is an extremely difficult diagnosis to make and one must be sure that no systemic diseases are present before applying this diagnosis. Tranquilizers are extremely successful in this disorder.

Summary

The neuro-otologic approach to the dizzy patient has been discussed and it is emphasized that not all cases of dizziness are due to abnormalities of the ear. None of the specific tests performed by the neuro-otologist are diagnostic in themselves, however, they must be considered together with the history, physical examination, and appropriate audiometric and vestibulometric testing.

Treatment of neuro-otologic disease is directed at alleviating the pathologic processes causing the vertigo. This is done by suppression of the abnormal vestibular mechanisms and decreasing fluid pressure within the inner ear. Surgical intervention is indicated only when medical treatment fails. The newest conservative surgical approach must be used if one is to preserve hearing as opposed to the older recommended destructive procedures.

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The Physician and the Florida Central Registry Act

The 1974 legislature passed Senate Bill 588 (Chapter 74-254 FS) that potentially has a significant impact upon all practicing physicians in the state and yet which is so little known probably that few are aware of it.

The bill mandates that physicians refer all severely disabled patients, as defined in the law, to the Department of Health and Rehabilitative Services within seven days. It must be with the patient's consent. The law gives as an example of a severely disabled person one with a spinal cord disease or injury resulting in permanent and total disability, amputation of extremities that require prosthesis, legal blindness, or a serious visual limitation in an infant sufficient to warrant special assistance to parents in the matter of child rearing and development.

The Department is directed to set up a Central Registry of these patients and to contact each one relative to the services the Department provides and referral to other state and private agencies. The law provided no funds for personnel to carry out the function or to reimburse physicians. The responsibility for implementing the legislation was given to the Division of Vocational Rehabilitation.

These mechanisms have been established: An incoming toll free WATS line to the Central Register has been assigned for the referring physician (800) 342-0825. At the time, he will be requested to provide the patient's name, age, address, type of disability, any additional information he feels pertinent, and the Social Security number, if known. If preferred, a card will be provided which can be prepared and sent to the Project Director, Central Register, 1309 Winewood Boulevard, Tallahassee 32301.

A. E. Ogden, M.D.

The law provides that the referral should be made only with the patient's consent. Any patient that does not wish to be referred for services of the Department of Health and Rehabilitative Services should not be referred.

The Central Register Project Director will welcome any comments or suggestions for improving this registration process for the physicians of Florida.

Dr. Ogden is medical consultant to the Division of Vocational Rehabilitation, Department of Health and Rehabilitative Services, Tallahassee.

Soft Tissue Loose Body as a Sequel of Osteochondritis Dissecans of the Talus

Case Report

H. I. Cross, M.D.

Abstract: During surgery on an ankle joint with osteochondritis dissecans of the talus preoperatively apparent by x-rays, a pedunculated soft tissue loose body was found at the corner of the ankle where the patient had noted repetitive "clicks" during self-manipulation for locking symptoms. While a cause and effect relationship cannot be proven conclusively, it is interesting to note that locking symptoms occurred during the last six months of a five year history of progressively worsening ankle pain, weakness and finally giving way, even on level floors. This case suggests consideration of a radiolucent loose body to explain symptoms of locking and giving way in a joint which does not demonstrate an osseous loose body by x-ray.

Osteochondritis dissecans is the most common cause of loose bodies requiring excision from joints.[1] Their production is well documented but the association of a soft tissue loose body with osteochondritis dissecans giving locking symptoms has not been reported as far as can be determined.[2-6]

Case Report

The patient, a 24-year-old man of Mexican-American descent, was admitted to the hospital in July 1971 with a five-year history of pain and instability of the left ankle. In 1966 he sustained two ill-defined injuries to the ankle and following noted some pain on running. Later that year in Viet Nam he jumped from a vehicle sustaining a definite inversion injury and the symptoms became significantly worse. The initial symptoms were the usual ones of a sprain and the ankle was treated as such but after resolution of the acute phase he noted the ankle "felt weak" and was "giving way."

Six months prior to admission and four and a half years after the injury, he noted the first pain since the injury. It became progressively more severe as did the instability. On admission he was noted "giving way" even while walking on level floors. He had been experiencing painful locking of the left ankle relieved by self-manipulation during which he experienced a "click" posterior to the medial malleolus. There had been no swelling since the injury.

Physical examination revealed diffuse anterior ankle discomfort with inversion or eversion and anteromedial tenderness to palpation as the only abnormal findings. There was no palpable or audible crepitus.

X-rays of the ankle were obtained on admission (Fig. 1). Routine hemogram, urinalysis, and serology were within normal limits.

At surgery the ankle was entered through an anterior medial incision, osteotomizing the medial malleolus for adequate visualization of the talar lesion. Slightly posterior to the apex of the talar dome, there was localized softening and fragmentation at the periphery of the articular cartilage. A cortical window was cut immediately inferior to the involved articular cartilage. Avascular cancellous bone only was found and removed, leaving a 10x8x3 mm defect whose lateral aspect barely involved the weight-bearing articular cartilage of the talus. Detected posteromedially and excised was a pedunculated loose body believed adequate in size and location to explain the locking symptoms. Histological examination revealed it to be synovial tissue with a cyst-like structure lined by synovial cells (Figs. 2, 3).

The postoperative course was uneventful. He wore a short-leg cast for 12 weeks, the last six weight-bearing. Progressive healing of the talar lesion was noted in periodic follow-up x-rays. At one year postoperative, he reported only occasional mild pain in the anterior portion of the ankle. There was no swelling, nor recurrence of locking or giving way. He was able to perform all his duties as a deputy sheriff, including running.

Discussion

This case suggests yet another etiology to be considered when confronted with symptoms of a locking, intermittently unstable joint. Specifically it may be a pedunculated synovial cyst of the ankle acting as a loose body either as an isolated lesion or in association with another lesion, particularly osteochondritis dissecans. A possible etiology is an inflammatory response to a chronic irritation.

From the Orthopedic Section, Surgical Service, Veterans Administration Center, Bay Pines, Florida.

Read before the Ninth Triennial Meeting of the Willis C. Campbell Club, Memphis, November 10, 1973.

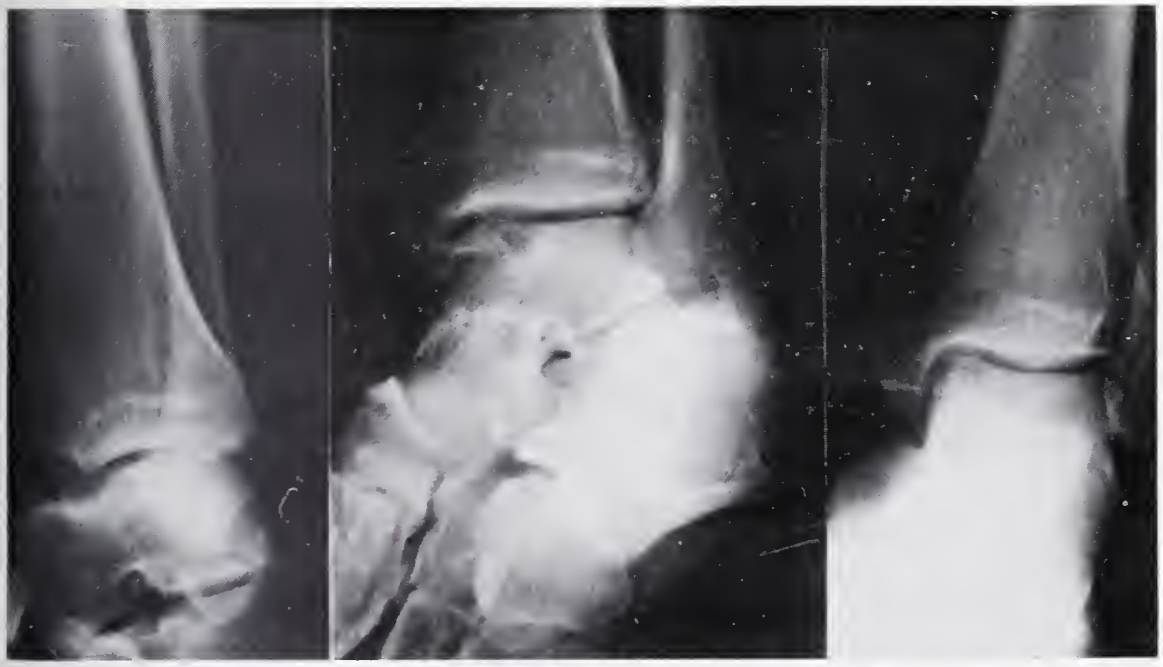

Fig. 1.—Left ankle x-rays on admission 7/20/71, showing lesion of superior-medial aspect of talus.

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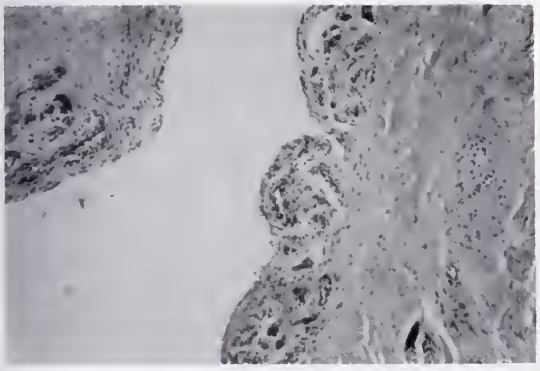

Fig. 2.—Photomicrograph (X100) of the soft tissue loose body showing it to be synovial tissue with a cyst-like structure lined by synovial cells.

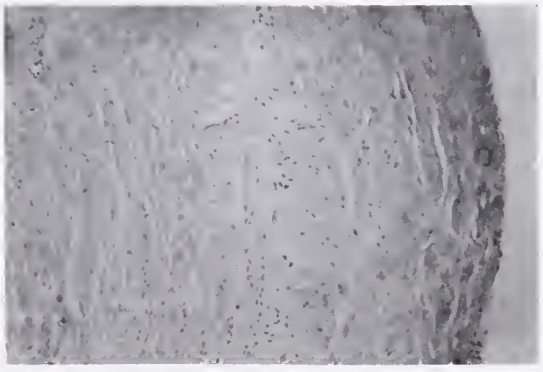

Fig. 3.—Photomicrograph (X100) of the soft tissue loose body-cyst wall.

Aortoduodenal Fistula
A Complication of Synthetic Grafts

Karl Smiley, M.D., F.A.C.S.

Abstract: Aortointestinal fistulae are frequently an unsuspected cause of upper gastrointestinal hemorrhage. Consequently the mortality and morbidity remain high. The fistula may be primary or occur as a secondary complication of previous aortoiliac reconstructive surgery. Aortointestinal fistulae communicate most commonly with the distal duodenum. They are often associated with an infected synthetic aortic graft. Little time is available for diagnostic studies as prompt surgery is necessary for control of the hemorrhage. Permanent repair and control of infection require closure of the fistula, removal of the synthetic graft and restoration of blood flow to the lower extremities by axillofemoral grafts.

Aortointestinal fistulae should be suspected in any individual with gastrointestinal bleeding and a history of previous aortoiliac reconstructive surgery. Primary aortoenteric fistulae are rare.[1] As vascular surgery developed, secondary aortointestinal fistulae were described as late complications of reconstructive aortoiliac procedures.[2] Initially deterioration of aortic homografts resulted in the development of fistulae. Subsequently synthetic grafts became the most commonly used aortic substitute and have resulted in increased patency rates and less aneurysmal formation; however, aortoenteric fistulae continue to occur. This complication may become an ever increasing problem due to the large number of aortoiliac reconstructive procedures being performed each year.

This article describes the successful management of a patient with an aortoduodenal fistula and reviews the problem as it relates to the use of synthetic grafts.

Case History

A 52-year-old man was admitted to Doctor's Hospital in Coral Gables, Florida, on August 3, 1973 with hematemesis, melena, and severe pain in both legs. His past history revealed that an aorto-right femoral and left external iliac bypass with knitted Dacron aortic bifurcation graft had been inserted in 1966 for relief of severe bilateral lower extremity claudication. Repair of a false aneurysm of the right femoral anastomosis was performed in 1967. He did well until 1971 when he moved to Florida and noted the onset of recurrent claudication. A second Dacron bifurcation graft was anastomosed end-to-side from the first aortic graft, which remained in place, to the left femoral artery and right popliteal artery. Recurrent bilateral claudication was again noted in December 1972.

The present illness began the evening of July 4, 1973 when the patient felt faint. This was followed by hematemesis and melena, and he was admitted to the Veterans Hospital in Miami, Florida, where two transfusions of whole blood were given. A barium enema and upper gastrointestinal series were normal. After discharge, a mild recurrent gastrointestinal hemorrhage occurred on August 1, 1973 for which hospitalization was not required. There was no history of peptic ulcer disease, hepatitis, alcoholism, or gastritis.

On admission to Doctor's Hospital the blood pressure was 110/60 mm. Hg., pulse 70 beats per minute and regular, and temperature 36C. The abdomen was flat without masses, tenderness, ascites, or venous collateralization.

Peripheral pulses were absent and the legs and feet were cool and mottled. Admission EKG, chest x-ray and blood chemistries were normal. The hemoglobin was 10.4 gm/100 ml and the hematocrit 34.3 mm. The patient was treated initially for peptic ulcer disease with antacids and a bland diet. Two units of whole blood were given by transfusion. A barium enema and two upper GI series were again negative. The patient had no recurrent bleeding but gangrene of the right leg developed, which required an above knee amputation on August 15, 1973. Three more units of whole blood were transfused at that time.

The patient was recovering uneventfully from the amputation when, on August 27, sudden onset of hematemesis was followed by syncope and later bright red blood was passed from the rectum. A nasogastric tube showed bright red blood. Examination of the abdomen revealed an epigastric pulsatile mass with bruit. The left leg was cool and cyanotic. Whole blood transfusions were started, but the blood pressure remained between 60 and 90 mm. Hg., and the central venous pressure was zero. After the rapid infusion of two units of whole blood he was taken to the operating room with the clinical diagnosis of probable aortoduodenal fistula.

At surgery, the small bowel and stomach were distended with blood. There was no external evidence of peptic ulcer disease. The liver appeared normal and there was no evidence of portal hypertension. The aorta was inspected and found to have an infrarenal Dacron bifurcation graft anastomosed end-to-side to the aorta.

A second Dacron bifurcation graft discovered distally had been anastomosed end-to-side to the proximal anterior wall of the first graft. There was no obvious pseudoaneurysm or inflammatory mass. The duodenum was closely adhered to the anastomosis between the aorta and the initial Dacron graft. Upon reflecting the duodenum a communication with the aorta was encountered at the site of the anastomosis between aorta and Dacron graft.

Bleeding from the aorta was controlled by local pressure while the duodenum was closed in two layers. Clean

instruments and a separately drapped surgical field were used as a left axillofemoral Dacron graft was constructed to restore blood flow to the left leg. Then the two abdominal Dacron grafts were removed to just beyond the bifurcation of each and the infrarenal aorta was ligated. A portion of the thrombus from the old graft was sent for culture and sensitivity and the patient was given Keflin intravenously. He received nine units of whole blood during and just after surgery.

Postoperatively the patient had a hematocrit of 40.7 mm and hemoglobin of 13.7 gm/100 ml. He had a persistent spiking fever and Enterobacteriaceae were cultured from the graft thrombus that were sensitive to Garamycin. The patient was started on but did not respond to antibiotics and continual infection of the remaining original grafts was suspended. On October 2 the residual limbs of the two previous Dacron bifurcation grafts were removed with subsequent resolution of fever.

The left axillofemoral graft continued to function well although no pedal pulse was palpable. The right above knee stump healed satisfactorily. The patient was discharged on the 56th postoperative day and was able to ambulate with the aid of a walker.

Discussion

Aortoenteric fistulae may present spontaneously or occur as a secondary complication of aortoiliac reconstructive surgery. A spontaneous fistula may develop from rupture of an abdominal aneurysm into the gut.[3] Secondary fistulae have been reported in reconstructive procedures following use of aortic homografts, endarterectomy and recently as a complication of the use of synthetic grafts.[4] The incidence of postoperative fistulae has been reported as high as 10% but it is usually between 2% and 4%.[5] The fistulous communication is most commonly into the distal duodenum because of its close proximity to the aortic graft anastomosis. Less frequently fistulae involve the jejunum and may involve any portion of the intestinal tract.[6]

Fistulae associated with synthetic arterial grafts originate at or near proximal or distal anastomosis. When not properly separated, bowel may adhere to the synthetic graft material. Pulsations secondary to blood flow in the graft can gradually erode the overlying bowel. After a period of months or years, the bowel may perforate and release gastrointestinal organisms into the immediate vicinity of the graft. Bacterial invasion with release of proteolytic enzymes may then result in dissolution and ultimate disruption of the suture line or graft material.[7] Primary infection may occur at the original procedure and result in fistula formation from secondary involvement of the adjacent bowel.

Fistulae may result in the absence of infection. A false aneurysm may occur at the site of anastomosis. This complication most often is associated with the use of silk sutures which rapidly lose tensile strength and may fragment in a matter of weeks in body tissues.[3] The false aneurysm may then erode into adjacent bowel without direct involvement of the graft material in the fistulous tract.

The most common symptom of an aortoenteric fistula is gastrointestinal hemorrhage which is often severe. Bleeding initially may be self-limited and some patients have melena for 4-6 weeks.[4] The fistula may be small and a laminated clot within the fistula or aneurysm can tamponade it and limit bleeding.[8] The bowel may acutely distend with blood then vigorously contract and increase the intraluminal intestinal pressure and, if this exceeds the lowered aortic pressure, stop the bleeding.

During the quiescent phase in patients with intermittent bleeding certain roentgenographic changes may be seen. A plain film of the abdomen may reveal a false aneurysm, or one may see a retroperitoneal hematoma as a para-aortic soft tissue mass. Where perforation has occurred, intestinal contents often enter the perivascular tissues and the external surface of the graft may be outlined by barium contrast studies.[9] Aortography may demonstrate a false aneurysm or occasionally the fistula itself.[3] Diagnostic studies are unobtainable in the majority of patients with massive bleeding for they require prompt operation for control of the hemorrhage.

Once an aortoenteric fistula is strongly suspected, immediate surgery is indicated. Inspection of the abdominal viscera for more common causes of gastrointestinal bleeding should be rapidly performed. Proximal control of the aorta is very helpful if it can be obtained. Dense scar tissue may encase the synthetic graft and anastomosis. If no other obvious source can be discovered the bowel should be dissected away from the underlying anastomosis. When the fistula is identified, it is divided. Balloon tamponade of the aorta through the fistula may allow control of bleeding until clamps can be placed on the aorta.[10] This technique also allows blood flow to continue to the lower extremities while the bowel is being oversewn.

Treatment of an aortointestinal fistula depends on the presence or absence of infection in the retroperitoneal space. If no obvious infection is present on gross or microscopic examination of the surrounding tissues, the existing synthetic graft may be used. Resection of the aorta to viable proximal tissues is performed and flow

reestablished with the existing graft.[3] Viable tissues should be interposed between the new suture line and the bowel if possible. Retroperitoneal cultures must be taken and intense appropriate antibiotic therapy begun. Hardy[5] recommends placement of a multihole polyethylene catheter adjacent to the proximal suture line for continuous administration of intra-abdominal Kanamycin and Cephalothin during the first postoperative week. At the same time a full spectrum of systemic antibiotics is given.

Proven or suspected infection of the synthetic graft or retroperitoneal space requires complete removal of the existing graft.[2] Ligation of the aorta without reconstitution of blood flow to the lower extremities frequently results in gangrene and loss of the limb. Insertion of a new graft in the infected field is often followed by another graft infection. Best results are obtained when the synthetic graft is completely removed, the infrarenal aorta ligated and blood flow reestablished with the lower extremities by use of a subcutaneous axillofemoral graft. Ehrenfeld et al[11] reviewed 40 reported cases of aortoenteric fistulae associated with synthetic grafts. The mortality rate was 62.5%, but it was lowest in that group treated by excision of the synthetic graft and use of axillofemoral grafts to reconstitute flow to the lower limbs.

Pinkerton[12] recently reported the 47th patient with an aortointestinal fistula associated with a synthetic vascular graft. His patient was the 18th known survivor in a group with an overall mortality of 62%. This paper presents the 48th known patient with a similar fistula and is the 19th reported survivor.

Aortointestinal fistulae are preventable. Rigid aseptic technique at the time of grafting together with preoperative, intraoperative and postoperative antibiotics help in preventing the ravages of infected prostheses. The prostheses should be placed so as to avoid anterior angulation and pressure against the overlying bowel. The sutures should be tied in such an area so as to minimize the chance of this penetrating the bowel. Improved synthetic graft material, such as knitted Dacron, is favored as it heals better than Teflon or other previously used synthetic grafts.[13] Most important there should be interposition of viable tissue between the graft and the posterior wall of the intestine. This may be accomplished by using peritoneal flaps, a free graft of fascia lata or simply interposing an omental flap.[7] These measures are helpful in reducing the chances of anastomotic disruption but, when aortoenteric fistulae occur, early diagnosis and treatment offer the best chance of salvage.

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INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. And, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children, particularly antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

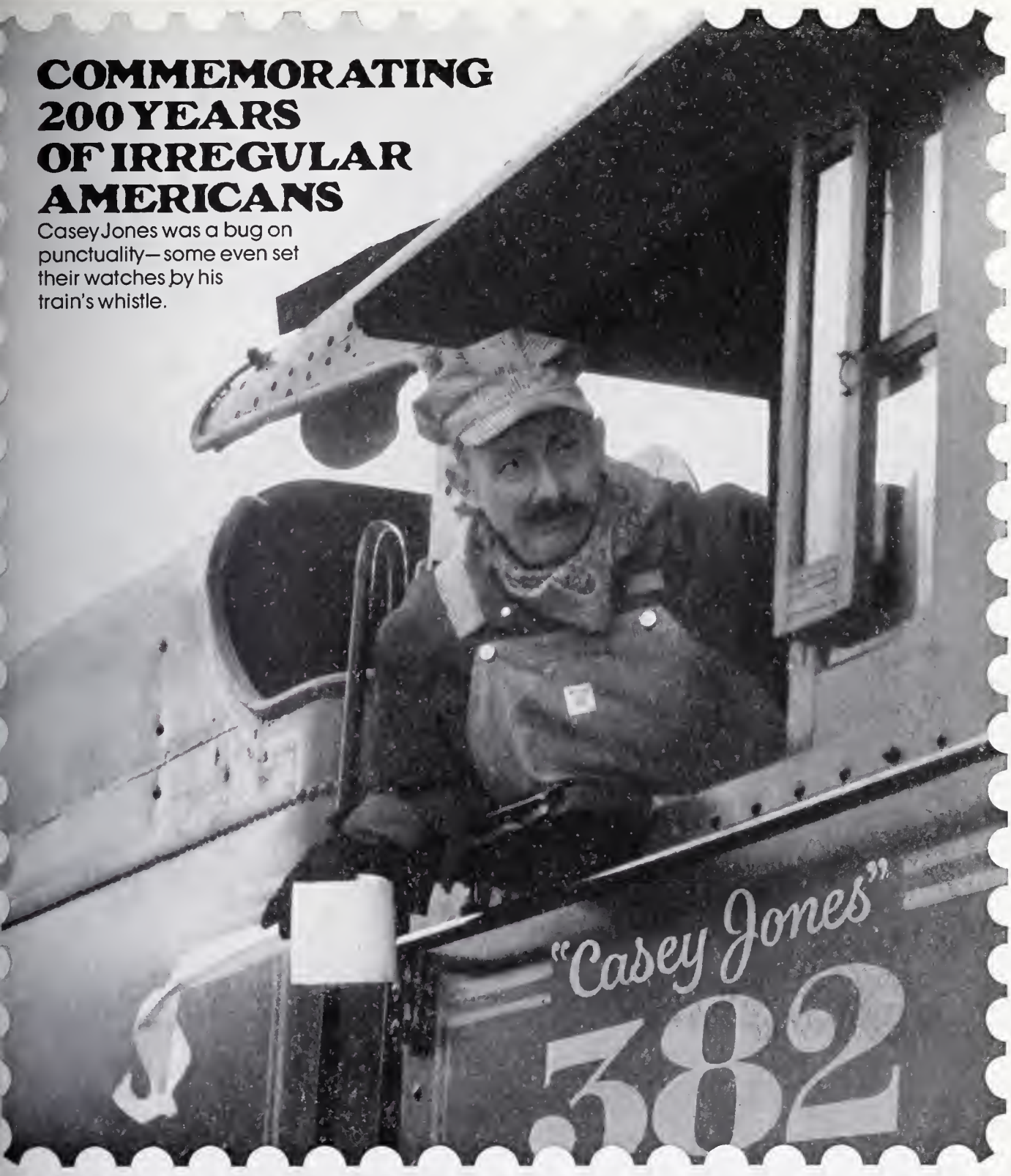
Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

COMMEMORATING 200 YEARS OF IRREGULAR AMERICANS

Casey Jones was a bug on punctuality—some even set their watches by his train's whistle.



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Now there's Modane.® One tablet with the evening meal provides comfortable laxation in the morning...for postoperative, pregnant, or geriatric patients. Because it's **reliable.** Because it's **predictable.** Because it's **gentle.**

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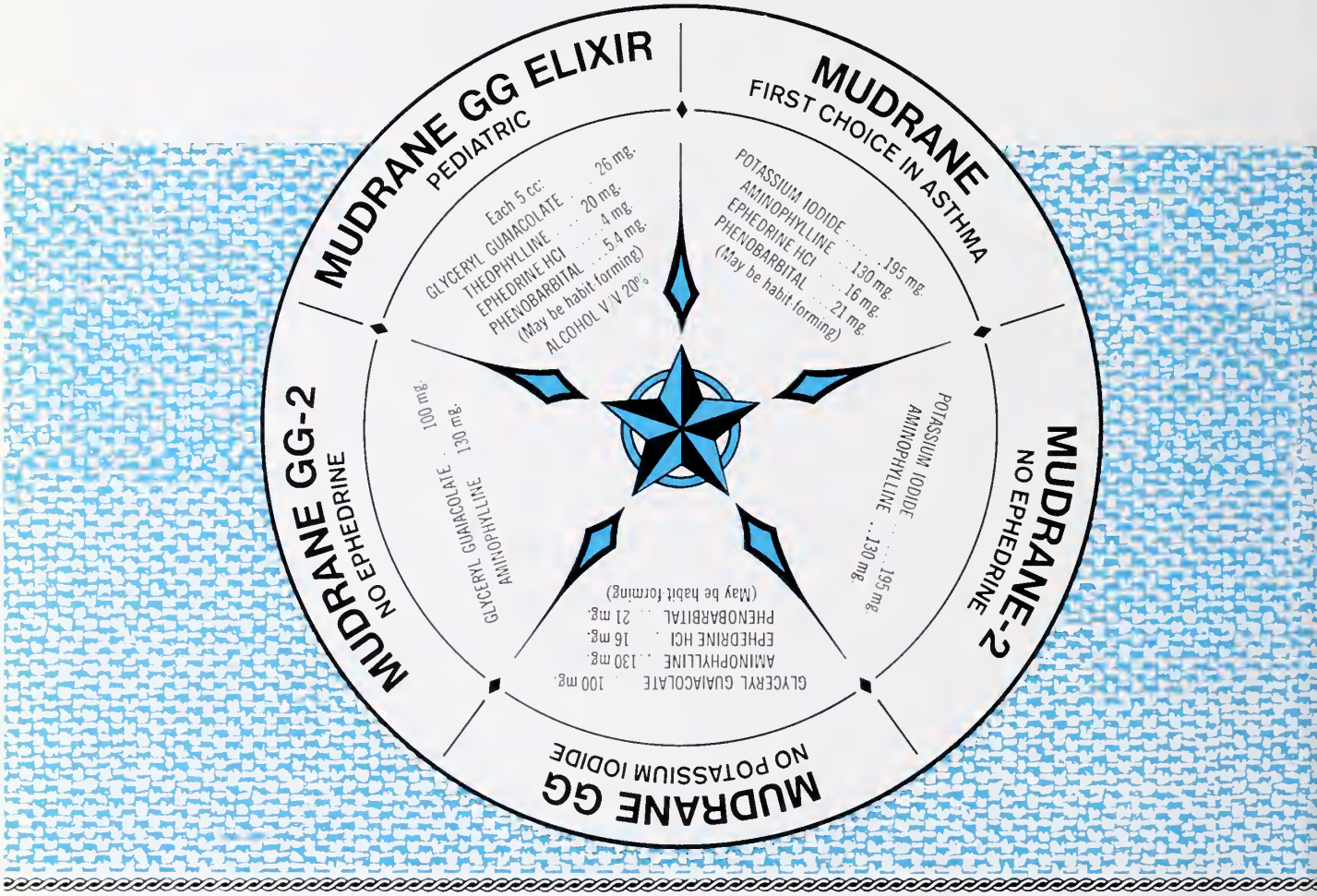
COLUMBUS, OHIO 43215

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

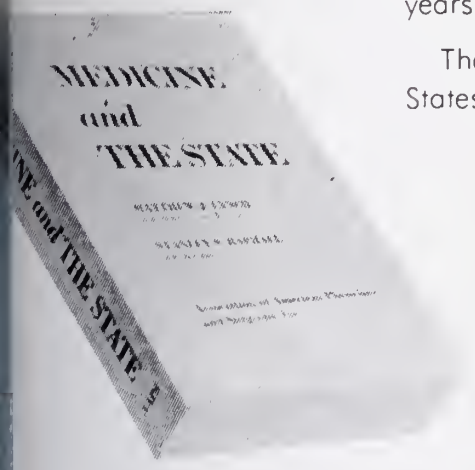
AAPS

THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS is a free, independent, non-governmental, voluntary organization of members of the medical profession. We are united for the purpose of analyzing the profession's problems and formulating actions to improve medical care for all Americans, preserve freedom of choice for patient and doctor, protect the practice of private medicine, and educate physicians and the public to recognize and resist schemes that would weaken or destroy our free-choice system of medical care.

The Association, founded in 1943 is nationwide with membership in all 50 states, Puerto Rico and the District of Columbia. It is nonpartisan, nonsectarian and nonsecret in character.

THE MEMBERS ARE DEDICATED TO: The ethics of the Physicians' Oath of Hippocrates to which medical doctors have bound themselves for over 2,000 years; and

The principles of individual liberty, to which the founders of the United States of America pledged their lives, fortunes and sacred honor.



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Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine®
(propantheline bromide)

a good option in peptic ulcer

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

makes sense in edema.*

Neither inconvenient, unpalatable, expensive potassium supplements nor special K^+ rich diets are needed as a rule. Just 'Dyazide' once or twice daily for control of edema. Serum K^+ and BUN should be checked periodically (see Warnings section).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

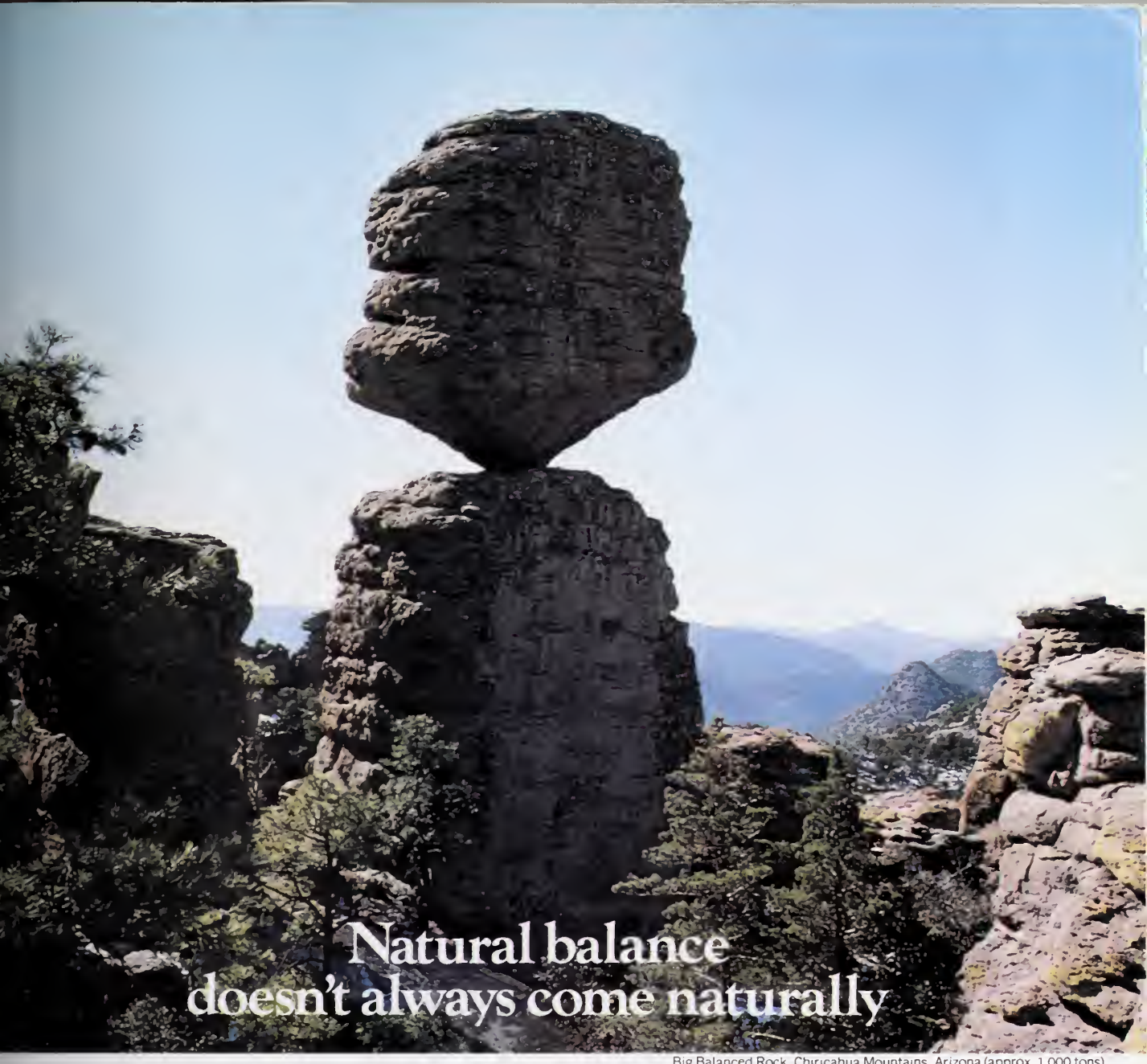
Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'Dyazide' gets excess water and salt out and helps keep essential potassium in.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with iseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored ablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for ausea, vomiting and dizziness associated with motion sickness.

RIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences – National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since mony strains are known to be resistant, routine sensitivity testing is recommended.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults – 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children – 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: "Rondomycin" (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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Special Articles

Dr. Astler Accepts the Gavel

Editor's Note: The following is the text of Dr. Astler's remarks to the House of Delegates upon his assumption of office as FMA president, April 27, 1975, Miami Beach.

Dr. Moseley, Mr. Speaker, Fellow Delegates, Ladies and Gentlemen:

I accept this gavel with the deepest amount of humility, a boundless amount of hope, and a limitless amount of enthusiasm. I realize this year will be one of many challenges. As your leader, and with your help, I promise to address myself to the duties of this high office which you have bestowed upon me.

The entire thrust of my remarks to you today has been altered by the unforseen events of recent weeks. Originally I had planned suggestions that primarily followed an aggressive economic and public relations program for physicians. My energies have been diverted elsewhere of late; not only my energies but your energies also! How well each one of us here in this room realizes the impact and pertinence of Thomas Payne's words, "These are the times that try men's souls."

My recollection of the American Revolution, its people and their aspirations, their problems, and courage, have been a source of inspiration to me during these trying times. I hope a brief recount will inspire you also. The American Revolution was not just a distant explosion. It has, and it will continue to be an active process. Today, 200 years after the first bloodshed at Lexington and Concord, there continues to be attacks on our ideology, our democratic form of government, and our system of health delivery. We physicians are somewhat analogous to the early colonists. We have been besieged with contemporary "intolerable acts" such as government intervention in medical education, medical licensure, specialty recertification, peer review, foundations, PRO and PSRO, Medicare, Medicaid, drug dispensing, hospital and nursing home admissions, and many others too numerous to mention. These attacks could factionate our Association, and so, I stand before you today and implore you to remain a united front. True, we are a minority in our society, but so were the colonists! True, we are fighting defensively, but so were the colonists. True, we weren't well organized but neither were the colonists. And true, the colonists enjoyed a moral advantage that came from what they believed to be a just cause, and so do we!

We need to fight for our values as our forefathers did; but today, the ballot is stronger than the bullet. Those who are not involved in politics are destined to be governed by those who *are involved.* We, as the colonists, need power to curb the injustices foisted upon us. We, as the colonists, need fundamentals to shape our destiny. In the earliest days of our country, the Continental Congress—which directed the conflict—was growing weaker as the struggle dragged on. It diminished itself to a virtual debating society. These people lacked unity and direction until they adopted written guidelines, which we know as the Articles of Confederation. These articles represented their beliefs and ideals.

Therefore, I stand before you today, not in a cavalier posture, but rather as a fourth generation fellow physician suggesting with humility a contemporary list of eight "Articles of Confederation" for our profession.

1. Unity, Fraternity and Kinship Among Doctors. There are those who would divide us over insurance issues, inter-specialty differences, consumer matters, differences with related health providers, and many others. I submit that we must stand together before *all* such outside interests united in common primary cause.

2. Involvement. This was strongly urged last year by Dr. Moseley, and seems even more essential today! We physicians are often so busy professionally that we do not find time to give of ourselves, or our assets, for critical social and political issues. I might add, in a nonchauvinistic way, that this applies equally to our wives.

3. Public Relations and Public Image. Public unawareness of our story mandates better communications and involvement of each one of us. Communications with the media, the legislators, the other professions, and above all *our patients.*

The public trust—once with us—seems somewhat eroded. Robert Louis Stevenson expressed this trust beautifully in this passage from *Underwoods;* "There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not unfrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such

as it is) of our civilization. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage."

I can recall my grandparents tending to pneumonia victims and spending hours at the bedside, prescribing almost useless nostrums, and speaking in an authoritative way about the coming "crisis." This, of course, alluded to the point in illness when the patient could no longer withstand a raging fever and therefore logically, must soon die, or muster the bodily defenses sufficiently to overcome. In either case, the physician emerged victorious! For if the unfortunate victim expired the family said, "The doctor did all that he could, but it was God's will." To the contrary, if the patient survived they joyfully credited the doctor and his nostrums with the recovery. Now for a moment, contrast this with today's physician who diagnoses pneumonia, cultures the organism, prescribes the appropriate antibiotic, achieves a cure within 48 hours, and then is resented deeply when his bill arrives. I therefore, ask each of you to consider this setting, and ask yourself if you have succeeded scientifically and *failed humanistically?* I can add that we are working on an ongoing public relations program at the state and county level, but, it is doomed without the earnest cooperation of individual members.

4. Compassion. In commenting upon compassion in *War and Peace,* Tolstoy said: "This is where the strength of the physician lies, be he a quack, a homeopath, or an allopath. He supplies the perennial demand for comfort, the craving for sympathy, that every human sufferer needs."

Perhaps we are sometimes too busy, ordering a battery of diagnostic tests or x-ray studies to respond to the patients' real life complaints, or to remember the laying on of hands.

5. Professionalism. Perhaps dignity or eminence would be more descriptive or suggestive of my plea.

John McClenahan expressed it well when he stated, "It is because we have begun to act like merchants, and in many instances to observe the same hours, that the public expects us to be regulated by the same restraints."

6. Courage. Courage to seek the truth and spell it out. Courage to speak out against untruths. Courage to defend and aid our fellow physician. Courage to seek the proper remedies for our patients and then pursue them boldly. Courage to remain silent when this would seem to be most prudent.

7. Accountability. Accountability not only for the future of our great profession, but for the lives of our fellow sufferers from the human condition. It seems to me we are the current holders of the noblest professional trust, passed on to us by our physician ancestors. Our personal accountability would seem to demand the passage of this trust to the next generation of physicians, not only improved scientifically, but, untarnished ethically and socially.

8. Hopefulness, Cheerfulness, and Optimism. These three attributes should be practiced in our daily lives. An optimist has been defined as "one who makes the most of all that comes, and the least of all that goes." Patients should never be left without hope! If only the assurance that suffering can be relieved. For it seems apparent, that if we physicians cannot convey some hope and cheerfulness into the sick room, then our patients' trust will soon be gone.

In closing, I should like to thank you all again for the trust you have placed in me, and perhaps each of you may obtain some manner of strength from these words written by Edna Groh, entitled, *Good Timber:*

The tree that never had to fight
For sun and sky and air and light,
That stood out in the open plain
And always got its share of rain . . .
Never became a forest king,
But lived and died a scrubby thing.

The man who never had to toil,
Who never had to win his share
Of sun and sky and light and air . . .
Never became a manly man,
But lived and died as he began.

Good timber does not grow in ease:
The stronger wind, the stronger trees,
The farther sky, the greater length:
The more the storm, the more the strength:
By sun and cold, by rain and snows,
In tree or man, Good Timber Grows.

Where thickest stands the forest growth
We find the patriarchs of both . . .
And they hold converse with the stars
Their broken branches show the scars
Of many winds and much of strife . . .
This is the common law of life.

I will need your support this year! Let us leave with the *togetherness* and strength to fulfill our challenge. Thank you.

Vernon B. Astler, M.D.
Boynton Beach

Are We at Armageddon?

James B. Perry, M.D.

The American physician long has been a source of dynamic strength. He is generous, hard-working, extravagant, independent, has a keen sense of priorities, and in the past has used this sense advantageously. These fine qualities and the others he possesses will be needed as he attempts to dispel a new spectre now appearing before him.

The number of liability claims confronting the physician are steadily increasing. The cost of settling or defending these claims has increased proportionately, according to actuarially sound insurance companies which maintain they have lost money and cannot continue to sustain the losses and remain in business. Already underwriters have stopped writing policies in a number of states. Premiums have gone up to levels that threaten to be financially disastrous.

Because of high premiums, young doctors just completing residency training and older doctors who have slowed down the pace of their practice are finding it difficult or impossible to meet the payments. In some instances the cost of protection is as high as $40,000 per year. The anesthesiologist whose usual contact with patients is confined to brief periods would be obliged to bill between $65,000 to $70,000 to collect enough money to meet such a premium. This does not include personal living expenses and office overhead.

The existing situation generates frightening thoughts of government control which would not be limited to insurance but would necessarily include such aspects of practice as relicensure and hospital record audits. Imagination conjures up the apparition of a far-flung bureaucracy. Currently, government-administered Medicare in Florida is faced with half a million unsettled claims. Think how vast the problems would be if insurance and its allied affairs were being similarly administered.

It appears that the something-for-nothing ethic so prevalent in the nation manifests itself in promulgation of a righteous grievance and need for redress. Some cases involve incidents which have little or no basis arena of moral turpitude. It is the high number of claims with questionable foundation that continue to escalate the problem.

The ad damnum clause is a feature to this, that is, the numeration of a specific demand for general damage in a personal injury or wrongful death. Headline hunting by parties alleging millions of dollars worth of damages tend to influence people to think some really serious problem does exist, and it may. The result is that the defendant often is considered guilty at least by inference and must necessarily prove his innocence. Examples are aircraft, train and bus accidents, dog bites, and recently a lion mauling. The individual does need redress of grievances, but the pound of flesh asked often makes him as guilty as the perpetrator of the alleged accident. How can injuries be worth $2 to $3 million when an individual's total life insurance is $20,000 to $50,000?

Plan Unfolding

The Florida Medical Association has introduced into the legislature a number of bills which although helpful do not appear to resolve the issue to any significant extent. Further proposals providing limitation of liability, mandatory pretrial arbitration and assigned risk pools, and pooling of licensed liability carrier assets and underwriting would seem to be necessary. A plan has now unfolded and received favorable legislative action.

In professional liability attention must be directed toward the problem of obtaining informed consent for a surgical procedure, for a medical procedure involving an element of risk, and for therapeutic measures classifiable as experimental. The approach should be realistic and reasonable. The patient and relatives must be told what the problem is and what the outcome of treatment may be. Then they should be able to give intelligent consent. The question of whether or not a full legal document is desirable in every case is under debate. A Statute of Fraud bill has been proposed which would prevent lawsuits against physicians by patients who interpret their words of hopeful encouragement as a warranty or guarantee of the results or the safety of a procedure. The bill would outlaw such interpretations unless given in writing.

Another bill proposes that the statute of limitations regarding a grievance be reduced to two years "from discovery" and to an overall limit of

four years after the procedure. Montana and California already have such a law. Another bill which has not been included but might help is prohibition of the res ipsa loquitor in malpractice cases. Some juries at times believe that injury does raise presumption or inference of negligence which, of course, is not the case but the problem needs to be clarified.

Additional problems requiring consideration are a part of the Florida Medical Association's proposals, but not as yet specifically law. An example would be the brain-damaged individual who faces loss of potential earnings and long-term institutional care. After one or two years he dies of a cause unrelated to the procedure for which large damages were granted. Is there any reason why nondependent relatives should suddenly become rich? This embodies the principle of structured settlement payments.

Another proposal which may be considered would be a bill to allow introduction into evidence (currently barred) of collateral benefit payments received by the patient because of the injury. Such evidence could conceivably mollify the amount of the jury verdict. An example is insurance which covers part of the cost of hospitalization and doctors' fees. Another would be lost wages currently computed on a gross basis rather than take home pay after the withholding tax deduction.

Contingency Fee Legislation

A number of bills have been proposed with the objective of limiting the contingency fee, that is, the portion of the verdict amount to be allocated for legal fees. Lawyers say "the contingency fee is the poor man's ticket to court." Though true, this is a time-worn cliche and not an answer to abuses the system has perpetrated. The New Jersey law has been tested in that state's Supreme Court. Apparently there is a fair and equitable limitation from the standpoint of compensation of the lawyer as well as protection of the public. Some suggested methods of limitation are: (1) The amount allowed should be regulated by court rule or legislation, (2) A retainer or contingency fee proposal should be signed by the client and the presiding judge and be known to the jury, (3) The dollar or percentage rate should be stated, (4) Division of the fee among several attorneys should be based on work performed, (5) The names of all involved attorneys should be recorded in the court proceedings so everyone will know who participated in the instigation, investigation, and eventual trial, and (6) On completion, an attorney should file an itemized claim statement with proper judicial authorities. The American Bar Association has approved the type of legislation that encourages these regulations.

Some facts have been assembled by an insurance company currently writing policies in Florida from closed claims in California, Nevada, Arizona and Florida during the period January 1970 through December 1974. They show that (1) the aggregate paid to plaintiff attorneys was five times the amount paid to defense attorneys, (2) more than half the total aggregate amount paid to plaintiff attorneys involved less than 2% of the cases, and (3) more than half the aggregate amount paid to plaintiff attorneys went to six attorneys.

The lawyers have rebutted contingency fee legislation. They are prepared to place before the legislature in Florida no less than 11 different bills, some of them just, many are not. They maintain that since they do not attempt to control medical fees, the medical profession should not attempt to dictate their fees and methods of practice. In this I heartily concur but an honest and forthright approach is necessary—not ventilation of emotions.

Additional legislative relief has occurred in the portion of the Omnibus Bill. This relief embodies the use of a mandatory arbitration panel. This panel is interesting and it embodies a concept that all alleged problems shall be mandatorily arbitrated with a doctor, an attorney and a judge on the panel. This will be absolutely necessary before a suit may be filed in the Circuit Court. Additionally, the findings of the panel will be mandatorily admissible as evidence into court should the problem go to court. Hopefully most problems will be settled by the findings of the panel. If they are not, the plaintiff on either side may take them to court; however, if they lose, the individual taking the problem to court is liable for all court costs and fees.

Another addition is strengthening of the Board of Medical Examiners. This is important because it gives the Board now the power to consider revocation of a license and this is part of state law. All of the above considerations have been united in a single Omnibus Bill entitled the Medical Malpractice Act of Florida of 1975.

Let's consider the lawyers' position. They state that five or ten years ago attorneys received

only one inquiry a year about the possibility of a malpractice suit against a physician. Today the same lawyers have two or three inquiries every day! Is this because physicians are practicing a poorer quality of medicine? The lawyers do not believe this is so. They do believe, however, and patients agree with them, that most physicians do not explain the nature of the problem in an understandable manner. Patients think physicians do not care about them as individuals and are only after the not-so-mighty buck. They believe we consider their questions stupid. Of course this is not true of all physicians.

The age of specialization continues to bring many excellent men into the medical profession, but they, all too often, have little heart and soul. How many practice by rote and have little or no understanding of human nature? Though they rarely make a mistake, they rarely make a single point in the game of life.

Causes of Current Chaos

There are elements of truth in speculation concerning the causes of the current chaos. Has it been brought about by a something-for-nothing generation? Examples abound in all walks of life: feather-bedding, rising union wages, and more fringe benefits unmatched by increases in quantity and quality of work. Insurance plans to cover the cost of becoming ill have promised much. Then came Medicare and Medicaid offering so much for so little. Could the medical profession deliver all the politicians promised? The right of every man to good medical care had now become law. Could it be that two decades of promises are the real reason for skyrocketing malpractice claims? No one, to my knowledge, has objectively investigated this facet of the problem.

Will the government, by absorbing the remaining freedom, pass laws to solve the liability question? Such control means additional bureaucracy and with it more manifestations of population unrest. This unrest, which most probably is the reaction of basically freedom-loving people to unwanted bureaucratic control, is becoming more evident every day. Such thoughts are speculations, of course; but I believe them to be worthy of consideration and intelligent reaction.

I have implied that our problems in liability insurance started with third party intervention. My real feeling is that they originated from a number of facts and facets which caused us to speed up in life, to act upon the basis of cold logic, to ignore human nature and become insensitive, calculating mathematicians trying to practice an art without the feeling of an artist. We have geared up our lives at the expense of natural law, and without the right or mentality, are trying to solve problems as if we were the Creator rather than the created. Is it any wonder that people have gotten fed up and are taking recourse in legally fighting back in any way they can?

Can we solve the problems by being more imperious? No. I believe we should try very hard to become more honest with ourselves, expose our mistakes and correct them. I would encourage members of the legal profession, and the legislators, to do likewise. The battle may not just be that of the medical profession. It could be rapidly approaching a chaotic, horrible climax, and assistance from any ally to delay, and perhaps halt the forward thrust, would be deeply appreciated.

▶ Dr. Perry, 300 Southeast 17th Street, Fort Lauderdale 33315.

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What Has Been the Effect of Peer Review?

Joseph G. Matthews, M.D.

The concept of Peer Review has been discussed for a considerable time now. It has been in effect six years, and I believe physicians would like to know how it is working and what is being accomplished.

The main question is: Has Peer Review affected doctors' patterns of practice and, if so, how? Before we get to that question, however, let's make sure we understand the areas of responsibility for Peer Review and where they lie.

Role of Florida Medical Foundation

The Florida Medical Foundation has contracted to perform Peer Medical Utilization Review (PMUR) for Blue Shield of Florida. Blue Shield's role has been to provide referral and statistical support, with the Foundation doing the actual Peer Review. As of this writing, 469 referrals have been made and 400 have been reviewed and returned to Blue Shield for appropriate follow-up action.

The Peer Review process reviews a relatively small number of physicians each year. Blue Shield's internal review eliminates many unnecessary referrals. For example, 8,883 physicians were reviewed by Blue Shield. The majority revealed no potential over-utilization while 880 required additional development. Blue Shield involves four levels of screening which include two levels of internal physician review. This screening produced only 64 referrals to the Peer Review process and of these 32 were found to have over-utilization after Peer Review. All of the 64 were reviewed with physician education as the main goal of the process.

Since the Foundation sees as one of its roles education not just those physicians directly involved in Peer Review but all physicians, this brings us back to the question: Has Peer Review affected doctor's patterns of practice and, if so, how?

Dr. Matthews is Chairman of the Board, Blue Shield of Florida and Associate Editor of The Journal of the Florida Medical Association.

Throughout the six years existence of Peer Review, studies have been conducted on the practices of those physicians directly involved in the process and they show clearly that Peer Review, understandably, has a very substantial effect upon their utilization. The question that has gone unanswered is: What was the effect on those physicians who were not directly involved in a Peer Review? In an attempt to answer Blue Shield statisticians undertook a study of the overall patterns of the practice of physicians without regard to their involvement in Peer Review. The idea was to sample physicians generally and then to attempt to measure the direct and indirect impact of Peer Review.

The study was conducted within the following criteria:

1. Each physician had to have substantial Medicare payments. Substantial payments was defined as annual Medicare payments of at least $25,000.

2. The physicians were selected without regard to their Peer Review involvement.

3. The review would compare the entire 1969 practice of those physicians selected against their entire 1972 practice, thus giving the study a "pre" and "post" Peer Review year comparison.

4. One hundred physicians were selected randomly after the above criteria were met.

A review of those randomly selected disclosed that of the 100 physicians, 80 had had no direct Peer Review contact.

Major Points Made by Statistical Study

The following points were made in the comparison of the 1972 practice to the 1969 practice.

1. The reviewed physician's patient number increased 9% as compared to 37% for the physician not reviewed.

2. The reviewed physicians reduced the number of services rendered 16% while the nonre-

viewed physicians increased the number of services rendered 29%.

3. The reviewed physicians cut their total charges significantly, whereas the physicians not reviewed apparently did not alter their charging habits.

4. The charge per patient was reduced significantly by those physicians who were reviewed while the charge per patient did not change significantly for those physicians not reviewed.

5. The reviewed physicians significantly reduced their number of services per patient while there was a lesser decrease of services per patient for those physicians not reviewed. This might indicate that reviewed physicians as well as those not reviewed have begun to ask if certain services they are rendering are medically necessary.

▸ Dr. Matthews, 1315 South Orange Avenue, Orlando 32806.

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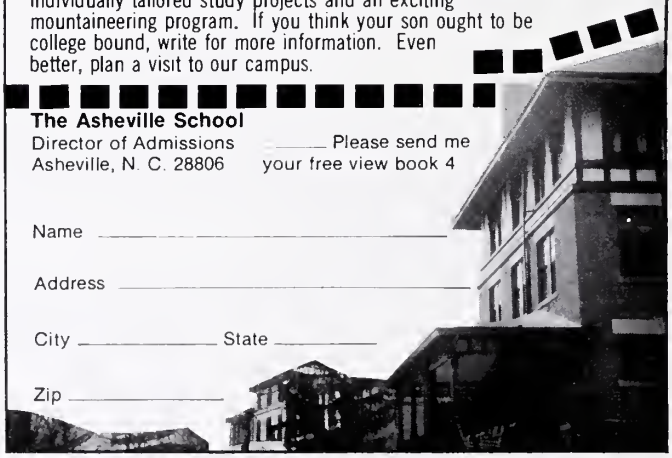

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

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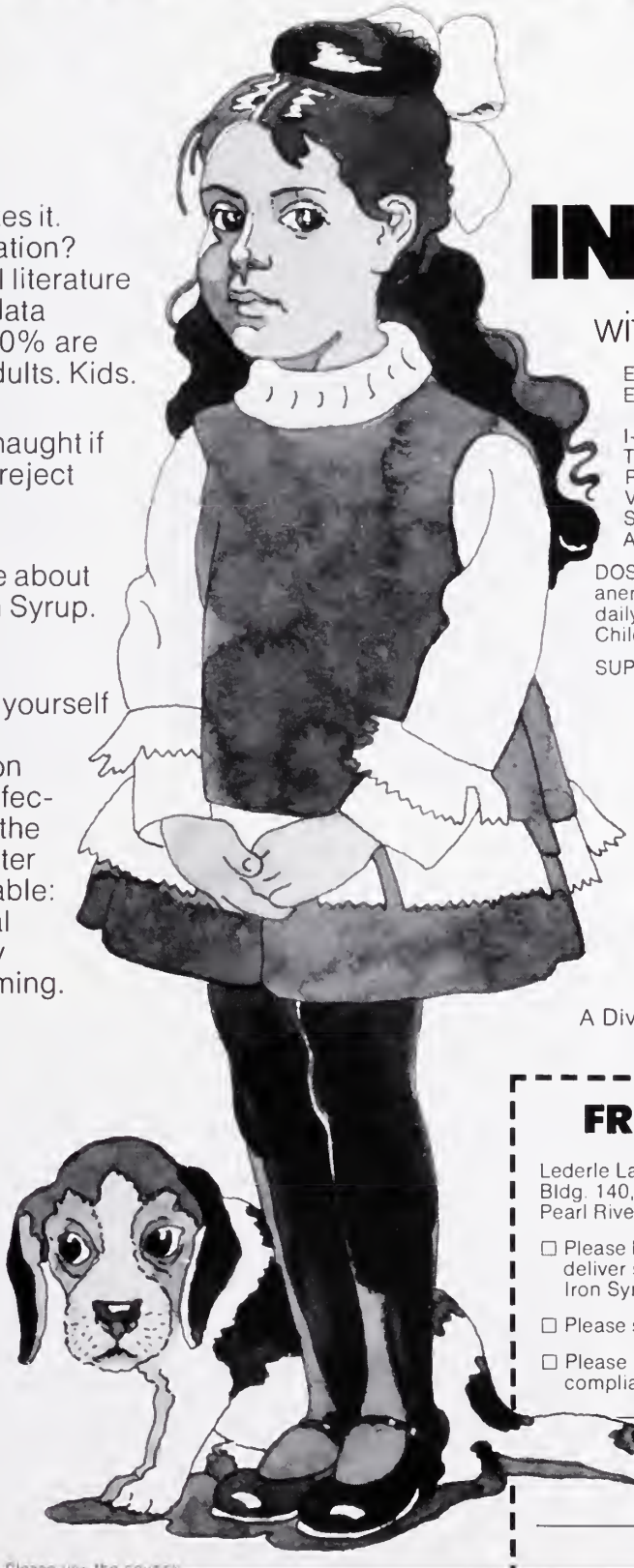

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Co-Directors: William J. Harrington, M.D., and Eric Reiss, M.D.
Program Coordinator: Jose S. Bocles, M.D.

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SCHEDULE

WEEK I—October 6-11, 1975			WEEK II—October 13-18, 1975		
October	6	Gastroenterology & Hepatology	October	13	Infectious Diseases
"	7	Cardiology	"	14	Rheumatology & Immunology
"	8	Pulmonary Diseases	"	15	Hematology
"	9	Endocrinology & Metabolism	"	16	Oncology & Genetics
"	10	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine	"	17	Renal Diseases
"	11	Neurology & Psychiatry	"	18	Hypertension & Acid-Base Disorders

LECTURES: The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10:00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 12:30 p.m. and from 5:00 to 7:00 p.m.

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Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:
a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.
b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.
d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.
e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.
Pregnancy: Use during pregnancy is to be avoided.
Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-H (8/74)
For complete details, including dosage, please see full prescribing information.

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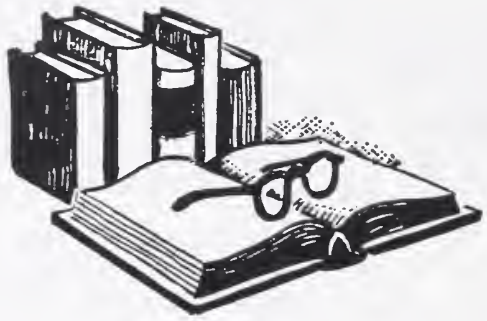

Book Reviews

Principles of Clinical Electrocardiography, Eighth Edition by Mervin J. Goldman, M.D. 400 Pages. Price $8.00. Illustrated. Los Altos, Calif., Lange Medical Publications, 1973.

For the title: Best Single Text of Electrocardiography, this reviewer recommends the above volume. Now in its eighth edition this book has long served the physician-in-training as well as the practicing electrocardiographer as a ready reference handbook. It is lucidly written and well illustrated with diagrams and representative electrocardiograms. The text is up-to-date and includes an introduction to vectorcardiography. This volume will answer the common problems of electrocardiography and, for problems requiring more extensive study, it provides several pages of carefully chosen references. It will not be the only text of electrocardiography you may wish in your library but it will be the one most frequently used.

William M. Straight, M.D.
Miami

Understanding and Overcoming Depression by James A. Brussel, M.D. and Theodore Irwin. 244 Pages. Price $6.95. New York, Hawthorn Books, 1973.

Written for the layman to explain the mechanism and treatment of depression, this book mentions famous depressive persons—Lincolin, King Saul, Marilyn Monroe, and Senator Eagleton. This book will not appeal to the sophisticated lay or medical reader. It could best be classified as a "popular" sketch of a psychiatric subject.

F. Norman Vickers, M.D.
Pensacola

The Diabetic Foot, edited by Marvin E. Levin, M.D. and Lawrence W. O'Neal, M.D. 262 Pages. 249 illustrations. Price $25.50, St. Louis, The C. V. Mosby Company, 1973.

The Diabetic Foot is a unique book devoted to diagnostic and therapeutic approaches to perhaps the most difficult chronic problem in the care of diabetes mellitus. Ten chapters, authored by different staff members of Washington University School of Medicine, cover medical, surgical, radiographic, bacteriologic and rehabilitative facets of management. They are well illustrated and each is followed by appropriate references. Bold type serves as introduction to various sections and subchapters to facilitate study.

Although well written and prepared, the book can serve only as a primer in the management of this diabetic problem. The attempt to unify in one volume the many disciplines required in management is a good one, but represents an introduction directing the reader to seek further information in the current texts and periodicals.

Harry W. Eichenbaum, M.D.
St. Petersburg

Handbook of Obstetrics & Gynecology, Fifth Edition, by Ralph C. Benson, M.D. 770 Pages. Illustrated. Price 8.00. Los Altos, California, Lange Medical Publications, 1974.

In 1971, I reviewed the 4th edition of this work for the Journal; four years later, I hold the 5th edition of this same work in my hand. Curiously, I am reminded of that old saw once heard so frequently on Dragnet: "Only the names have been changed to protect the innocent." The present edition is the same size, same color, has approximately the same number of pages, same tables on the inner covers, almost the same preface, practically identical Table of Contents chapter for chapter, same figures, same illustrations with a very few exceptions.

Yes, there are a few differences: the title is embossed in silver rather than in gold. For some reason, the helpful chapter on medical genetics has been deleted and six pages on the subject have been incorporated in chapter six (The Full-Term Infant).

Essentially, then, this is a re-review of the 4th edition. The 770 pages are divided into 17 chapters on obstetrics and 12 on gynecology. The first section covers everything DeLee and Greenhill does, though not in such detail, prompting me to emphasize the fact that this is a compact handbook to be used for quick reference rather than to be studied as a standard text. The author makes this clear in the preface: "it was never intended to be a substitute for more complete textbooks on obstetrics and gynecology, but a supplement to them."

Although, in the preface, Professor Benson states, "many sections have been extensively revised" and proceeds to list these sections, I see very little change in some of them. For example, emotional problems in obstetrics and gynecology, investigation and treatment of the infertile patient, and ovarian tumors have been changed very little. I am surprised that gonorrhea, the nation's second most frequently reported communicable disease and one referred to as a venereal disease is found under "Vaginitis" and not under "Venereal Infections." There is no update in treatment of this disease from 1971 to 1974 according to Dr. Benson. It is also surprising in a book directed to the practicing physician, the resident, the intern, and the medical student, that there is no reference to rape, a crime of great proportions in America and one which will surely involve the practicing physician and the resident, even the intern, in one way or another.

On the whole, however, the volume is well integrated. Tables and illustrations are employed with telling effect and help to clarify the text and give the reader a peg upon which to hang his memory. The pictures by Mrs. Schaubert have a sparkling clarity and support the axiom that one picture is worth a thousand words.

The volume is a valuable assert not only on a generalist's book shelf, but in a back pocket of a house officer; however, if one already owns the 4th edition of the book, I would suggest he refrain from purchasing the latest edition. The difference is so slight.

Arthur F. Schiff, M.D.
Miami

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D. 640 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1974.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Birth Defects, edited by Arno G. Motulsky and W. Lenz. 373 Pages. Illustrated. Amsterdam, Excerpta Medica, 1974.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 721 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Psychiatry in Primary Care by Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 Pages. Price $12.95 St. Louis, The C. V. Mosby Company, 1974.

Lifesaving, Rescue, and Water Safety by The American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Garden City, New York, Doubleday and Company, Inc., 1974.

In Defense of the Body by Roger Lewin. 146 Pages. Illustrated. Price $2.50. Garden City, New York, Anchor Press/Doubleday, 1974.

The Malnourished Mind by Elie A. Shneour. 209 Pages. Illustrated. Price $2.95 New York, Anchor Press/Doubleday, 1975.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Mental Retardation by editors: Julius B. Richmond, M.D., Chairman; George Tarjan, M.D.; Robert S. Mendelsohn, M.D. 134 Pages. Price $2.00. Chicago, American Medical Association, 1974.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1975.

Current Surgical Diagnosis & Treatment, 2nd Edition, by J. Englebert Dunphy, M.D. and Lawrence W. Way, M.D. 1,123 Pages. Illustrated by Laurel V. Schaubert. Price $15.00. Los Altos, California, Lange Medical Publications, 1975.

Medical News Around the State

NEW ACP GOVERNOR . . . Leighton E. Cluff, M.D., Professor and Chairman of the Department of Medicine at the University of Florida, has been elected the American College of Physicians Governor for Florida. Dr. Cluff is reported to be the first ACP Governor for Florida to be selected from the academic community and the first to be elected by a popular vote of some 800 ACP members and fellows in Florida.

DISTINGUISHED LAYMAN DIES . . . Prevost A. Coulter, Pensacola newspaper columnist who received FMA's second Distinguished Layman Award in 1974, died on April 10. He had been honored by the American Medical Association and the Escambia County Medical Society as well as by FMA for his outstanding reporting on medical affairs.

DR. STEWARD CLOSES PRACTICE . . . W. Dean Steward, M.D., who served as President of the Florida Medical Association in 1967, has closed his internal medicine practice in Orlando and has joined the Florida Division of Health in Jacksonville. Dr. Steward initially will be associated with the tuberculosis control program.

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A working partnership against the pain of gas and spasm

Measuring cause and effect

Cause: High levels of anxiety
Effect: Exacerbation of irritable bowel syndrome

When barium fills the whole colon, there also a reflux through the ileum so that ileum is superimposed on colonic shadows. The tube-type descending colon revealed normally associated with the diarrheal base of the irritable bowel syndrome.

Case History:* 27-year-old female

Before treatment

Chief Complaint: Abdominal pain and diarrhea.

Present Illness: Intermittent, left-sided, lower abdominal pain for over a year; pain, unassociated with menstrual periods or eating, lasted several hours. Abdominal symptoms occurred in attacks lasting 1-2 days with remissions of 3-4 days. Diarrhea accompanied attacks. No weight loss, nausea or vomiting.

Personal History: Married, 2 children. Somewhat restless, tense and anxious.

Physical Examination: 8/16/73. System review within normal limits. Weight 95 lbs. Petite, pleasant, cooperative patient with no obvious signs of illness.

Abdomen: Spastic, tender sigmoid colon. Otherwise normal.

Rectal: Normal mucosa and stool. No rectal bleeding or excess mucus or fat in stools.

Sigmoidoscopy: Normal sigmoid mucosa.

Laboratory tests: Within normal range. No occult blood in 3 successive stool examinations.

Impression: Irritable bowel syndrome. X-rays 7/25/73 showed tube-type descending colon. Librax, one capsule *q.i.d.*, prescribed as adjunctive therapy on 8/23/73. Symptoms of anxiety evaluated with Hamilton Anxiety Scale on same date.

*Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. 07110.

Although this is an actual case history, not all cases of irritable bowel syndrome can be expected to respond this rapidly to therapy.

Before Evaluation	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
0 1 2 3 4	
Pretreatment	
Total Score	1
Anxiety	
Somatized Anxiety	

Undue anxiety—often a forerunner of irritable bowel syndrome

Irritable colon is a disorder commonly seen in the average physician's daily practice. Expressed as diarrhea and/or constipation, the disorder affects mainly the colon's tonicity. Usually spasms are produced, mediated through the autonomic nervous system. Such abnormal activity can easily derive from emotional stress, which causes parasympathetic stimulation. Hence the direct relationship between anxiety and irritable bowel syndrome. Reducing anxiety, one of the causative factors, can be expected to counter the effect, exacerbation of irritable bowel syndrome.

Librax is the logical adjunct in treating irritable bowel syndrome

☐ Dual action of Librax helps relieve both anxiety and somatic symptoms.

☐ Librax alone provides both the antianxiety action of Librium® (chlordiazepoxide HCl) and the antisecretory-antispasmodic action of Quarzan™ (clidinium Br).

Relief of symptoms linked to relief of anxiety

Hamilton Anxiety Scale	
Parameters	**After Evaluation**
Anxious Mood	0 1 2 3 4
Tension	0 1 2 3 4
Fears	0 1 2 3 4
Intellectual	0 1 2 3 4
Depressed Mood	0 1 2 3 4
Insomnia	0 1 2 3 4
Somatic (muscular)	0 1 2 3 4
Somatic (sensory)	0 1 2 3 4
Cardiovascular Symptoms	0 1 2 3 4
Respiratory Symptoms	0 1 2 3 4
G.I. Symptoms	0 1 2 3 4
G.U. Symptoms	0 1 2 3 4
Autonomic Symptoms	0 1 2 3 4
Behavior at Interview	0 1 2 3 4
Patient's first evaluation was made 8/23/73 prior to treatment. The second evaluation, made 10/4/73, shows concurrent drop in anxiety and somatized symptoms.	**Posttreatment** Total Score 4 Anxiety 1 Somatized Anxiety 3

After treatment

Abdominal pain and discomfort less troublesome although still some frequency and looseness of the bowels. Patient felt significantly better and less anxious. Bowel movements returned to regular pattern when therapy discontinued on 10/4/73.

10/4/73: Second Hamilton Anxiety Scale completed.

Follow-up (2 months later): Patient off all therapy, normal bowel function, no abdominal pain, no significant anxiety feelings or undue tension or nervousness.

Charted at left, the Hamilton Anxiety Scale ratings show how somatized anxiety symptoms—especially gastrointestinal, the complaint rated highest—diminished along with anxiety symptoms. The first six paramcters plus "bchavior at interview" measure anxiety and the rcmaining sevcn, somatized anxiety. Between thc first and second evaluations, the sum of the anxiety and the sum of the somatized symptoms each decreased by 4 points on the rating scale.

☐ Both components are conveniently contained in a single capsule.

☐ Dosage is adjustable within the range of 1 or 2 capsules 3 or 4 times daily; up to 8 capsules daily in divided doses.

☐ One capsule before each meal and two at bedtime usually prescribed.

Please see summary of product information on following page.

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Initial R_x

The initial prescription permits evaluation of patient response to therapy

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Follow-up

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

for the anxiety-related symptoms of irritable bowel syndrome · duodenal ulcer · upper functional gastrointestinal disorders

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan™)—bottles of 100 and 500; Prescription Paks of 50, available singly and in trays of 10.

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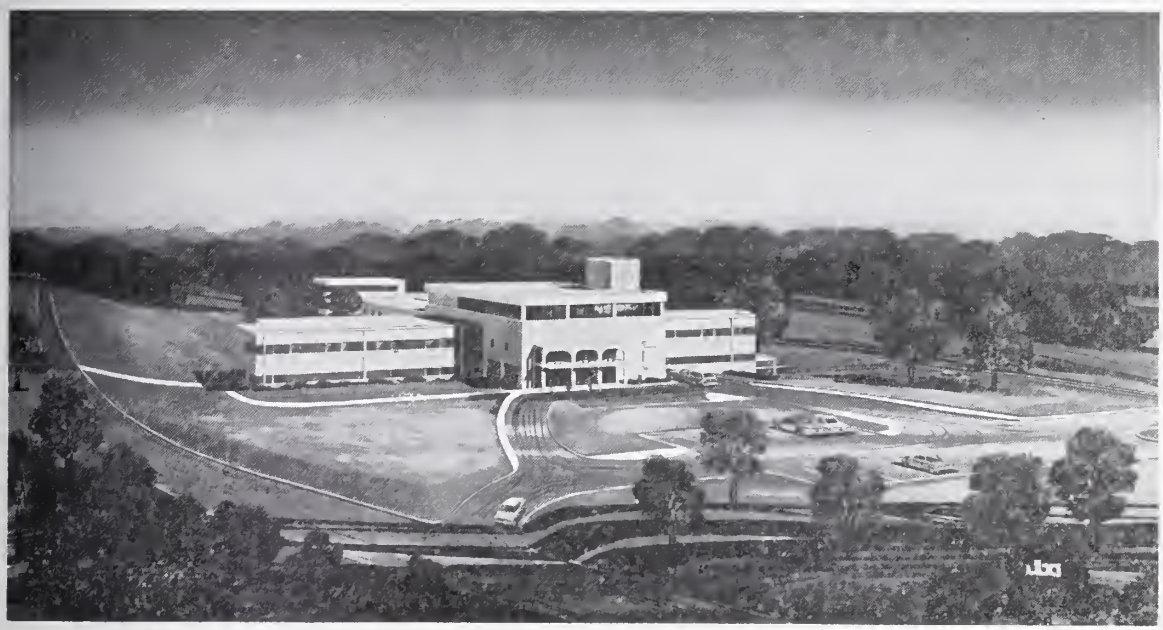

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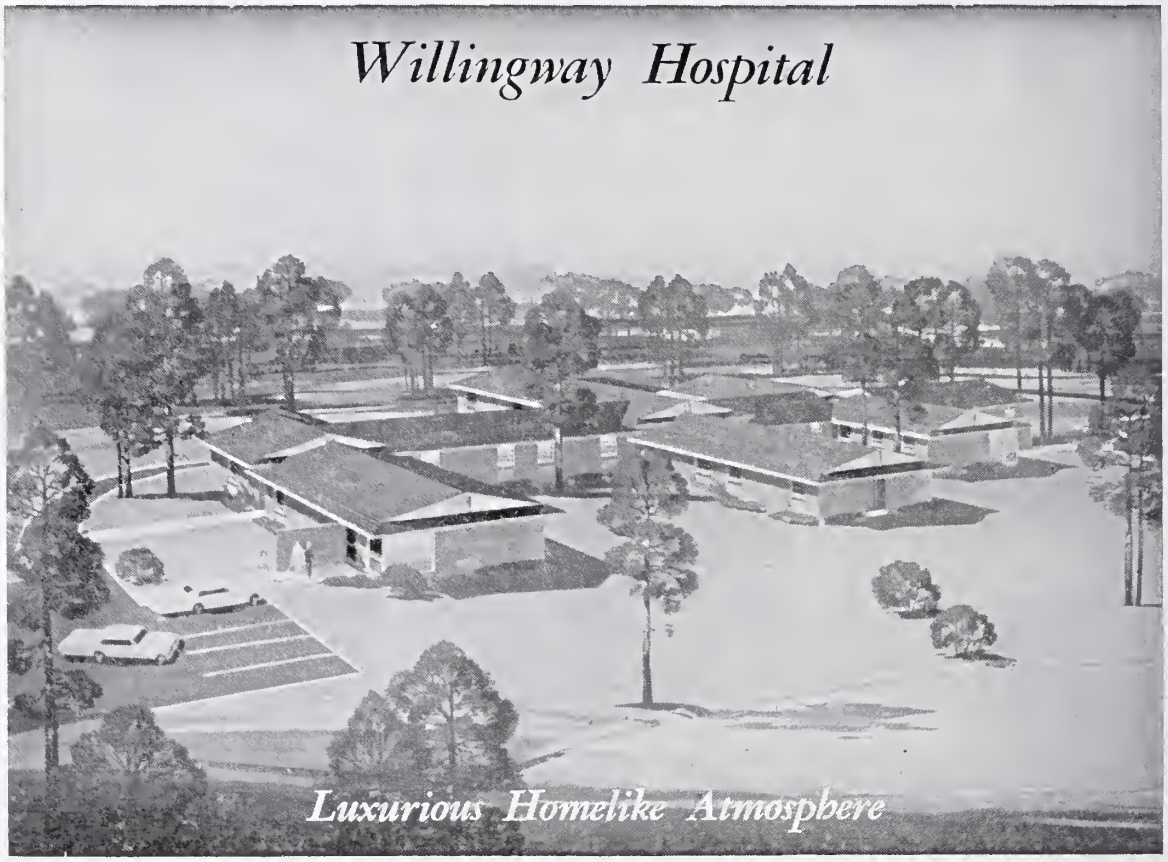

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FAMILY PRACTITIONERS, General Internist, Internist-Cardiologist, Internist-Rheumatologist, Internist-Pulmonary Disease and fulltime Emergency Room physicians needed for outstanding practice opportunities. Forty-eight physician medical group, affiliated with 312-bed hospital located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

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INTERNIST, 36, ABIM eligible, wants to buy practice or join physician ready to retire. Also will consider partnership or group practice. Write P.O. Box 341, Hasbrouck Hts., New Jersey 07604.

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real estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

OFFICE SPACE, 1,300 sq. ft., partitioned and air conditioned, adjoining Tampa's best neighborhood. Excellent for G. P., internist or pediatrician. Rent $5 per sq. ft. Inquire Fermin Rodriquez, phone: (813) 839-8431.

NOW LEASING: 60,000 sq. ft. medical building now under construction in north Tampa, next door to University Community hospital, a private 400-bed general hospital, same area as medical school and VA hospital. Ready for occupancy early in 1975. Call Tampa 971-5353 or 977-0144.

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DISTINCTIVE SUITES, FORT MYERS, in southwest Florida. 1,600 and 1,000 sq. ft. in new medical center. Present tenants are x-ray lab., physical therapist, four surgeons and a dentist. $4. per sq. ft. Six months free rent. Phone collect evenings Tohari (813) 542-0501.

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MEDICAL SUITE NOW AVAILABLE, Maitland, Florida. 1,600 feet, prime location. Abundant parking. Suite is complete and ready to go. Near hospitals, Orlando, Winter Park and Altamonte Springs. All services provided. Contact Owner, L. Kalmanson, P. O. Box 1276, Maitland, Florida 32751. Phone (305) 645-5000.

PENSACOLA, FLORIDA. Physician retiring, has active practice. Newly redecorated office, adjacent to one of the largest hospitals. Rent or purchase building and equipment. Will introduce. Available June 1. Write C-678, P. O. Box 2411, Jacksonville, Florida 32203.

practices available

PRACTICE AVAILABLE IMMEDIATELY: General practice, solo and well established high gross and net. Modern, beautiful building over 3,000 sq. ft., fully equipped. Ideal for one or two MD's. Experienced staff and well kept records. Reasonable lease or purchase property, near Orlando. Exceptional opportunity! Reply to C-674, P.O. Box 2411, Jacksonville, Florida 32203.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P. O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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In patients with chronic or frequently recurrent urinary tract infections

Bactrim™ outperforms ampicillin.

In new multicenter studies a higher percentage of Bactrim-treated patients maintained clear cultures for four, six and eight weeks.

See charts on following page for details of studies.

For chronic cystitis or pyelonephritis evidenced by persistent bacteriuria, frequently recurrent infections or infections associated with urinary tract complications, when infection is due to susceptible organisms.

Bactrim™

(80 mg trimethoprim/400 mg sulfamethoxazole)

Before prescribing, please consult complete product information, a summary of which follows:
INDICATIONS: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii*.

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.
The recommended quantitative disc susceptibility method (*Federal Register* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy, "Intermediate susceptibility" also indicates a likely response and "Resistant" that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

DOSAGE: Not recommended for children under 12.
Usual adult dosage: 2 tablets b.i.d. for 10 to 14 days.
For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

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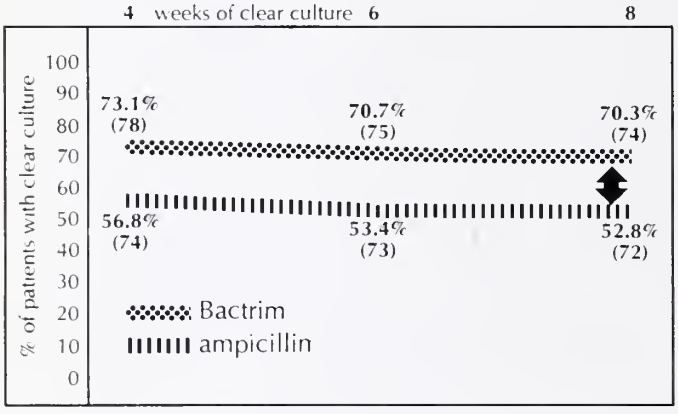
In new multicenter studies of patients with chronic or frequently recurrent urinary tract infections

Bactrim™
(80 mg trimethoprim/400 mg sulfamethoxazole)

outperforms ampicillin

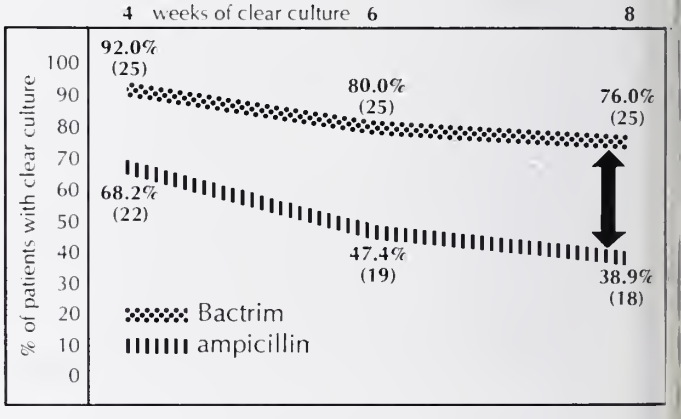
Bactrim vs ampicillin. 10-day therapy. 157 patients.



Criterion for clear culture: 1000 or fewer organisms/ml of urine.
Numbers in parentheses: No. of patients evaluated for this time period.

17.5% The Bactrim plus.
Patients maintaining clear cultures for 8 weeks
Bactrim: 70.3%
ampicillin: 52.8%

Bactrim vs ampicillin. 28-day therapy.* 53 patients.



Criterion for clear culture: 1000 or fewer organisms/ml of urine.
Numbers in parentheses: No. of patients evaluated for this time period.

37.1% The Bactrim plus.
Patients maintaining clear cultures for 8 weeks
Bactrim: 76.0%
ampicillin: 38.9%

In two multiclinic, double-blind studies of patients with chronic or frequently recurrent urinary tract infections, Bactrim maintained a higher rate of clear cultures than ampicillin. All patients had "significant bacteriuria" (100,000 or more organisms/ml of urine) on two consecutive pretreatment cultures; many had previously undergone multiple treatment programs and/or surgery. Organisms were *E. coli* and *Proteus mirabilis*.

Side effects were relatively mild (e.g., nausea, vomiting, rash), but more serious side effects can occur with the agents studied. Please consult the manufacturers' product information for all warnings, precautions, contraindications and adverse reactions.

*While the usual therapy regimen for Bactrim is 10 to 14 days, patients with chronic urinary tract infections can be and are treated for substantially longer periods with standard agents such as ampicillin. These studies, therefore, include both 10-day and 28-day courses of therapy. In both studies dosage was one 500-mg ampicillin capsule q.i.d. or two Bactrim tablets b.i.d. plus placebos to make each drug regimen appear identical.

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...e see preceding page for summary ...oduct information.

THE JOURNAL
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PROCEEDINGS ISSUE

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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JULY COVER — The painting on the cover by William F. Hogan, M.D., Fort Lauderdale, won the Editor's Award at the Woman's Auxiliary Ninth Annual Benefit Art Show during the FMA annual meeting, April 23-27, 1975 in Bal Harbour.

President's Page

The Sick Doctor

Florida enacted the first "Sick Doctor Statute" in the United States. This legislation empowered the Florida State Board of Medical Examiners to revoke, suspend, restrict, or otherwise control the practice of physicians who were emotionally, physically, or otherwise unable to practice with reasonable skill and safety. Previous to this law, this procedure was often time consuming and difficult to achieve. The Medical Board now has emergency suspension powers upon the receipt of evidence indicating reasonable cause. Upon the concurrence of the Executive Director, the President of the Board, and one other member of the Board, an emergency suspension may be evoked. Such physicians must have a full hearing before the Board within 60 days. The physician has the right to legal counsel, the presentation of witnesses and evidence. The results of any such hearing may not be used in any other legal action against the physician.

A license to practice medicine is a privilege, not a right. The sovereign power to grant or deny such license rests with the various states. The enabling act has been used judiciously in Florida, and has now served as a model for several other states to enact similar laws.

To date, 35 physicians have been disciplined under the "Sick Doctor Statute" and only one has appealed the decision. Fifteen are back in practice; six returned to restricted practice; two are on probation; five were suspended; three revoked; four dead or retired. The use of this statute by the Medical Board has served primarily to promptly remove physicians suffering from alcoholism, drug addiction, and incapacitating mental illness. It has helped these physicians, protected the citizens of Florida and answered our critics who claim we do not police our own. Hopefully, the majority of these physicians may be rehabilitated and returned to a useful and more productive practice. Most, if allowed to continue, would have soon reached a more terminal endpoint of jail, enforced hospitalization, serious accident, or even death. The obvious harm to the sick physicians' patients, family, and the medical profession need not be recounted.

It should be of concern to us physicians that most such actions taken against physicians have followed after being initiated by lay persons and/or civil authorities. It seems obvious that this responsibility rests primarily with the medical profession.

The sacred medical trust left to us by previous generations of physicians should be passed to subsequent members of our profession improved scientifically and untarnished morally and ethically.

If this is to occur, we must actively pursue the critical inspection and policing of our own profession. To fail in these efforts against a small minority of our profession, can only serve to erode our image and standards of excellence. Lastly, the sick doctor himself has little or no chance of rehabilitation until he is removed from his protected environment and offered the chance for recovery.

Vernon B. Astler

COMMEMORATING 200 YEARS OF IRREGULAR AMERICANS

Casey Jones was a bug on punctuality—some even set their watches by his train's whistle.

Just get me to the station on time. For 200 years, Americans have been in a hurry. But some things just don't happen on schedule—like bowel movements in a constipated patient. And for 200 years, Americans have dealt with this problem in a variety of ways—and with varying degrees of success.

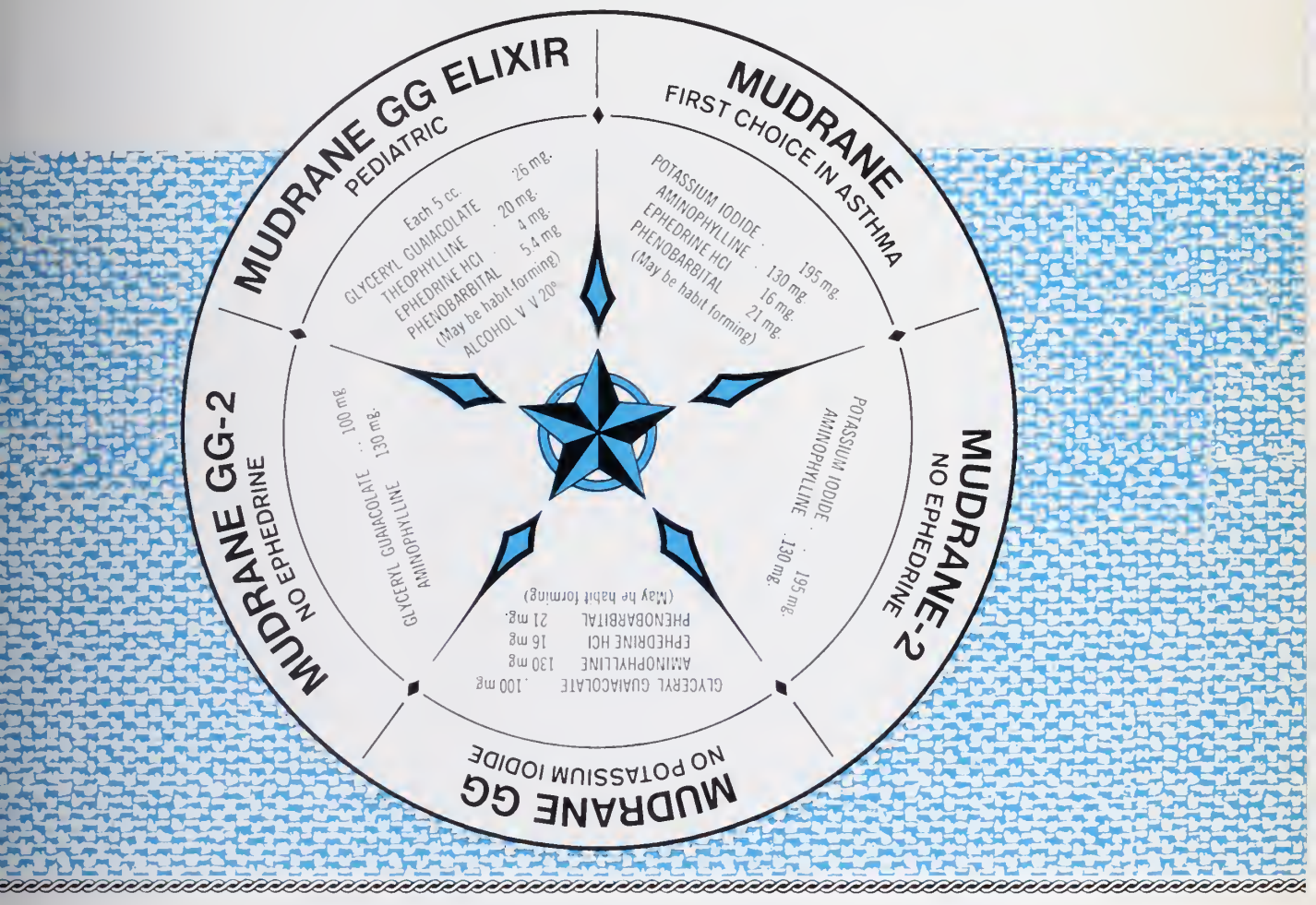
Now there's Modane.® One tablet with the evening meal provides comfortable laxation in the morning...for postoperative, pregnant, or geriatric patients. Because it's **reliable.** Because it's **predictable.** Because it's **gentle.**

MODANE®
LAXATIVE TABLETS

WARREN-TEED
PHARMACEUTICALS INCORPORATED
SUBSIDIARY OF ROHM AND HAAS COMPANY
COLUMBUS, OHIO 43215

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

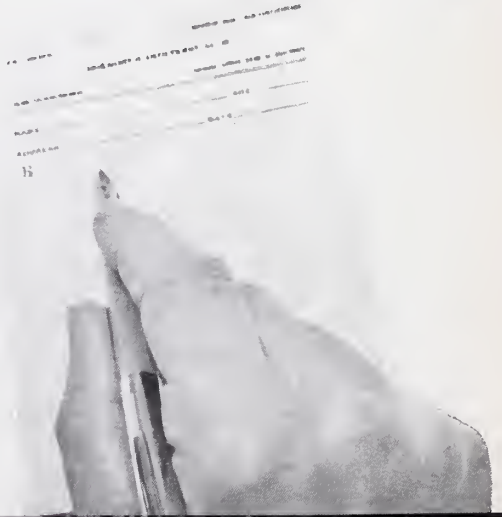
P·M·A

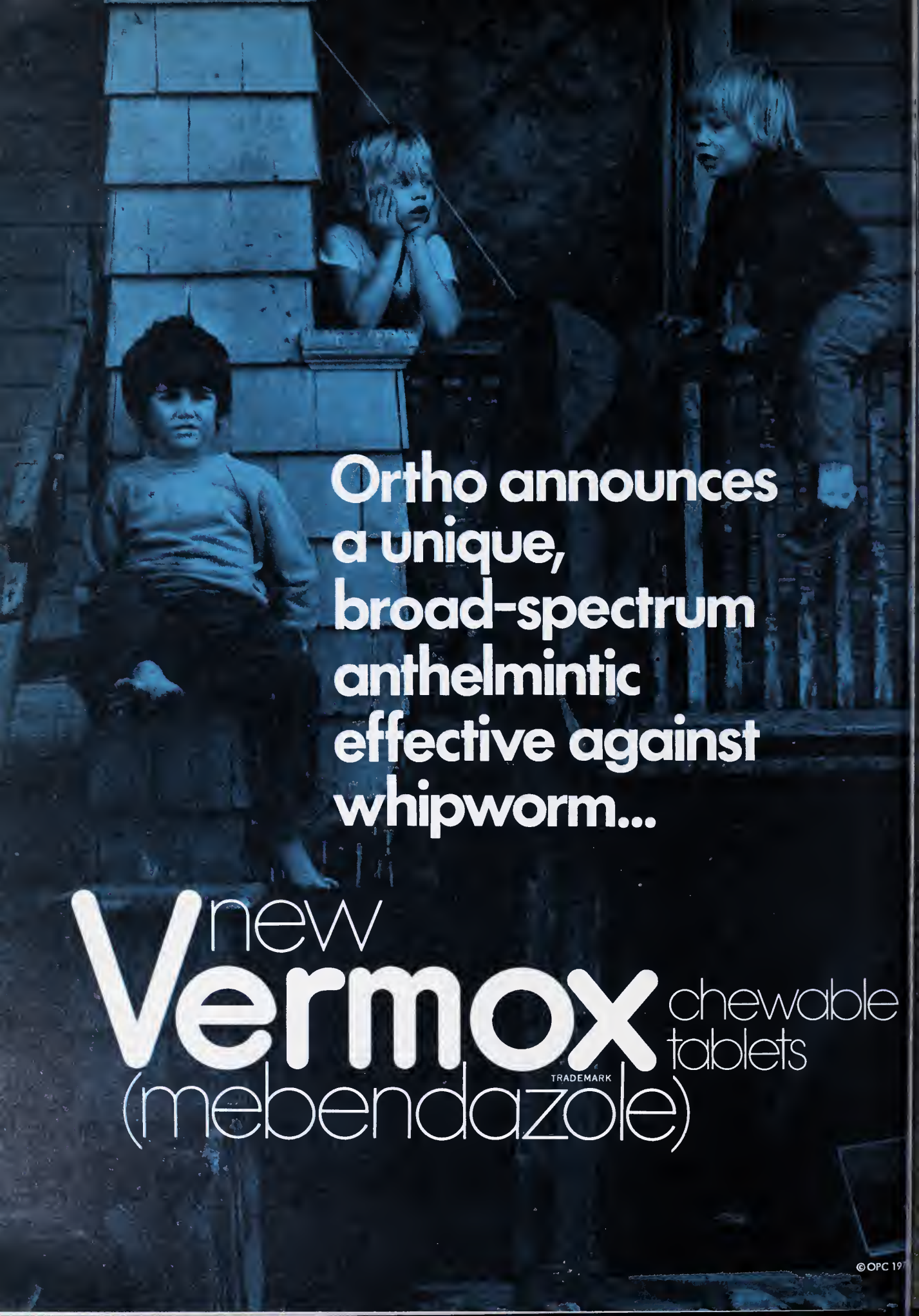
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402.

protecting the integrity of your prescription

Bioequivalence




Ortho announces
a unique,
broad-spectrum
anthelmintic
effective against
whipworm...
new
Vermox
TRADEMARK
chewable
tablets
(mebendazole)
©OPC 19

.and highly effective
igainst roundworm, hookworm and pinworm
n single or mixed infections

No dosage calculations — one simplified dosage, egardless of weight or age†

hipworm, roundworm, hookworm and mixed infections:
chewable tablet b.i.d. for 3 consecutive days
inworm: 1 chewable tablet

he patient is not cured three weeks after treatment, a second course of treatment is advised.

ighly effective	Mean Cure Rate (Range)	Mean Egg Reduction (Range)	No. Patients	No. Studies
hipworm *(Trichuris)*	68% (61-75%)	93% (70-99%)	211	(5)
undworm *(Ascaris)*	98% (91-100%)	99.7% (99.5-100%)	101	(2)
ookworm	96% (—)	99.9% (—)	23	(3)
nworm *(Enterobius)*	95% (90-100%)	———	524	(7)

mplicity of administration patients can take the tablet at any time. It can be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

ot a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

onvenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

ell tolerated transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

ermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk ould be considered before treating these children. Vermox is contraindicated in regnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

dications Vermox* (mebendazole) is indicated for the treatment of *richuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *scaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common ookworm), *Necator americanus* (American hookworm) in single or ixed infections.

ficacy varies in function of such factors as pre-existing diarrhea and astrointestinal transit time, degree of infection and helminth strains. ficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
gg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

ntraindications Vermox is contraindicated in pregnant women e: Pregnancy Precautions) and in persons who have shown hyper- nsitivity to the drug.

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults.
For control of trichuriasis, ascariasis, and hookworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.
If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

*TRADEMARK

Ortho Pharmaceutical Corporation,
Raritan, New Jersey 08869

OJ 667-4R © OPC 1974

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogen Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

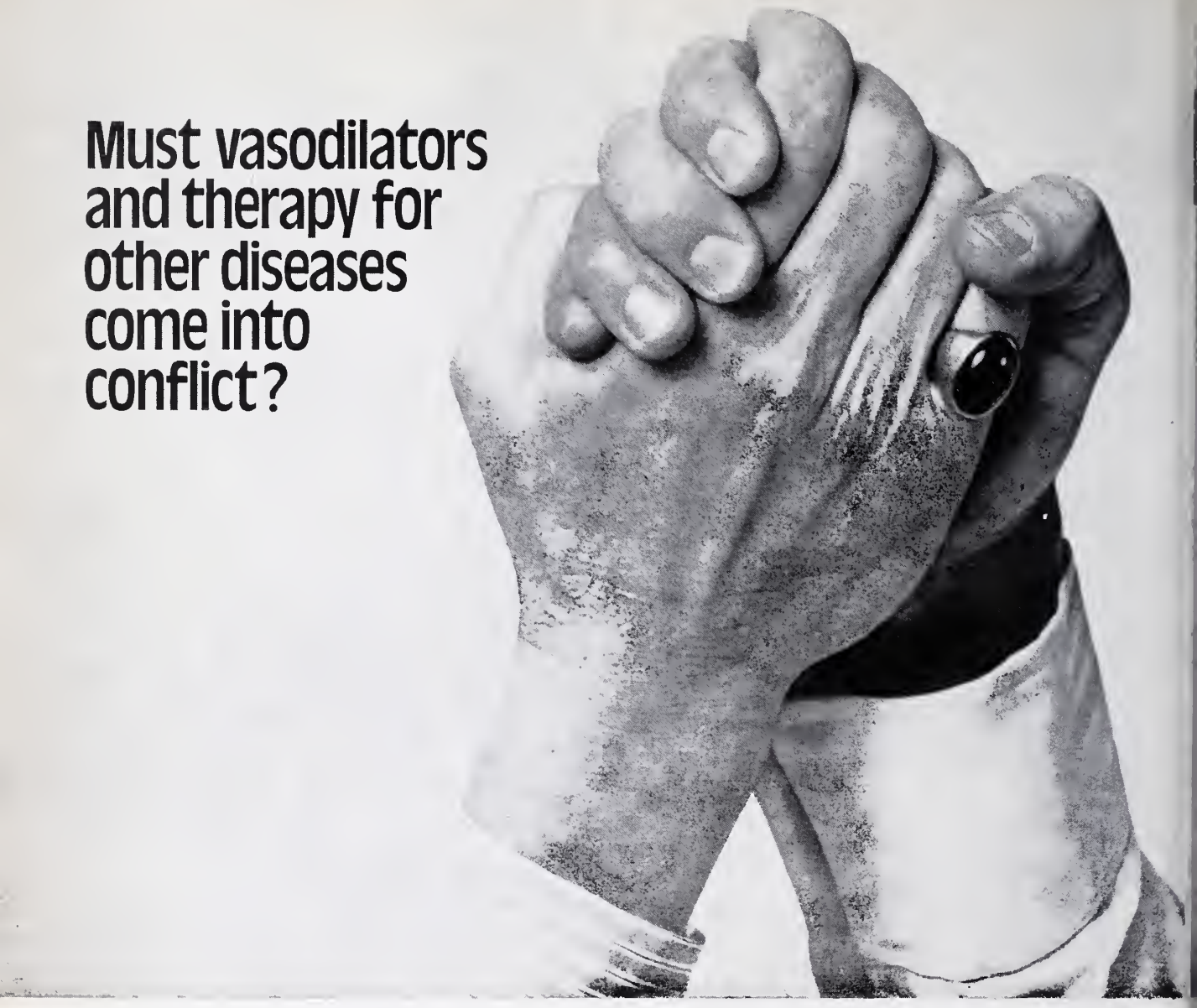
BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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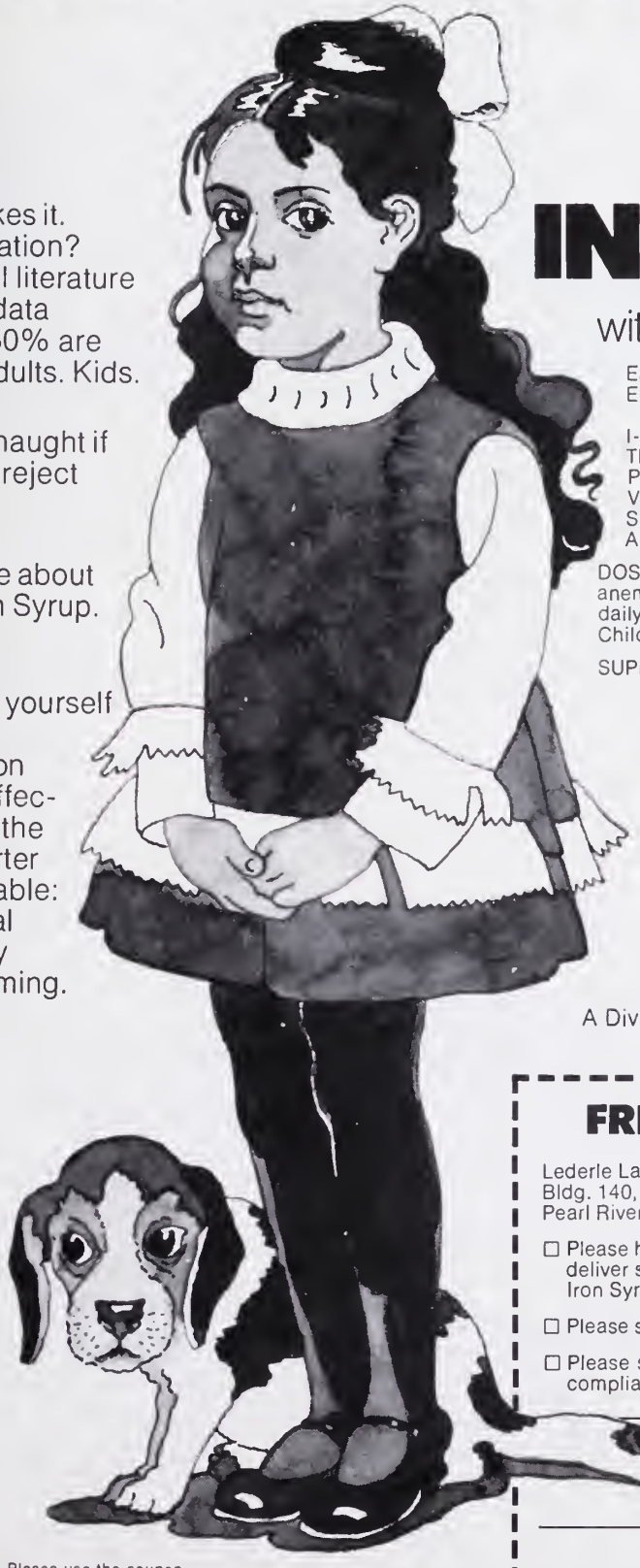
Mead Johnson LABORATORIES

NO IRON IS BIOAVAILABLE.



Unless the kid takes it. Frivolous observation? Hardly. The medical literature is now replete with data showing that 25 to 50% are drug defaulters.* Adults. Kids.

Everything is for naught if the kid's taste buds reject the product.

That's what's nice about INCREMIN with Iron Syrup. It really tastes okay.

Now, to convince yourself that INCREMIN with Iron Syrup makes iron "bioavailable" by effectively delivering it to the patient, request starter samples. Also available: A print of this original artwork (without any text) suitable for framing.

INCREMIN® with IRON Dietary Supplement Syrup

Each teaspoonful (5 cc) contains:	
Elemental Iron (as Ferric Pyrophosphate)	30 mg
l-Lysine HCl	300 mg
Thiamine HCl (B_1)	10 mg
Pyridoxine HCl (B_6)	5 mg
Vitamin B_{12}	25 mcgm
Sorbitol	3.5 Gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency anemia—Children and Adults—1 tsp. (5 cc) daily. Treatment of iron-deficiency anemia—Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

Want a list of relevant references? Please use the coupon.

FREE SAMPLE COUPON

Lederle Laboratories
Bldg. 140, Room 104R
Pearl River, N.Y. 10965

☐ Please have your representative deliver samples of INCREMIN with Iron Syrup.

☐ Please send print suitable for framing.

☐ Please send bibliography on patient compliance problems.

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Zip

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169-5

It's The Doing That Counts

Wouldn't You Like to Belong to an Organization That Gets Things Done While Others Sit and Ponder or Look for Reasons Why It Can't Be Done?

Then You certainly will want to join the Association of American Physicians and Surgeons. It's an Organization that *Does* Get Things Done.

- While others were wondering what PSRO was all about, AAPS was warning physicians in pamphlets, newsletters, speeches and at its meetings that PSRO was a vicious and evil device to achieve government control of physicians and their patients. AAPS also advised patients how PSRO would deprive them of constitutional rights.

- While others talked about how to resist PSRO and still others just gave up, AAPS filed suit in Federal District Court seeking to protect the rights of physicians in private-practice by having the PSRO Law declared unconstitutional.

- AAPS is the only nationwide medical organization that has consistently battled federal agencies and Congress to protect the rights of private-practice, fee-for-service physicians and has not once in its 32-year history sought or accepted government money or otherwise compromised ethical principles.

- AAPS early warned physicians of the movement to make medical staffs subservient to hospital administrations and was the first to distribute a pamphlet delineating rights and responsibilities of medical staffs and how they can protect their rights. The pamphlet contains model bylaws for medical staffs.

- Malpractice & other Insurance benefits.

AAPS is an *action* organization dedicated to preserving your professional freedom.

YOUR PATIENTS NEED YOUR FREEDOM

You can help preserve it by joining AAPS.

APPLICATION FOR MEMBERSHIP

Association of
American Physicians and Surgeons
2111 Enco Drive, Suite N-515, Oak Brook, Illinois 60521

for office use only
dated recd.

Exclusively Devoted to Building and Preserving Private Medical Care

Name_____ M.D.
First Middle Initial Last

Address_____
Street City State Zip

Medical Society Membership - County_____ State_____

U.S. Congressional District #_____ Type of Practice_____

Physician Sponsor_____ Signature of Applicant_____

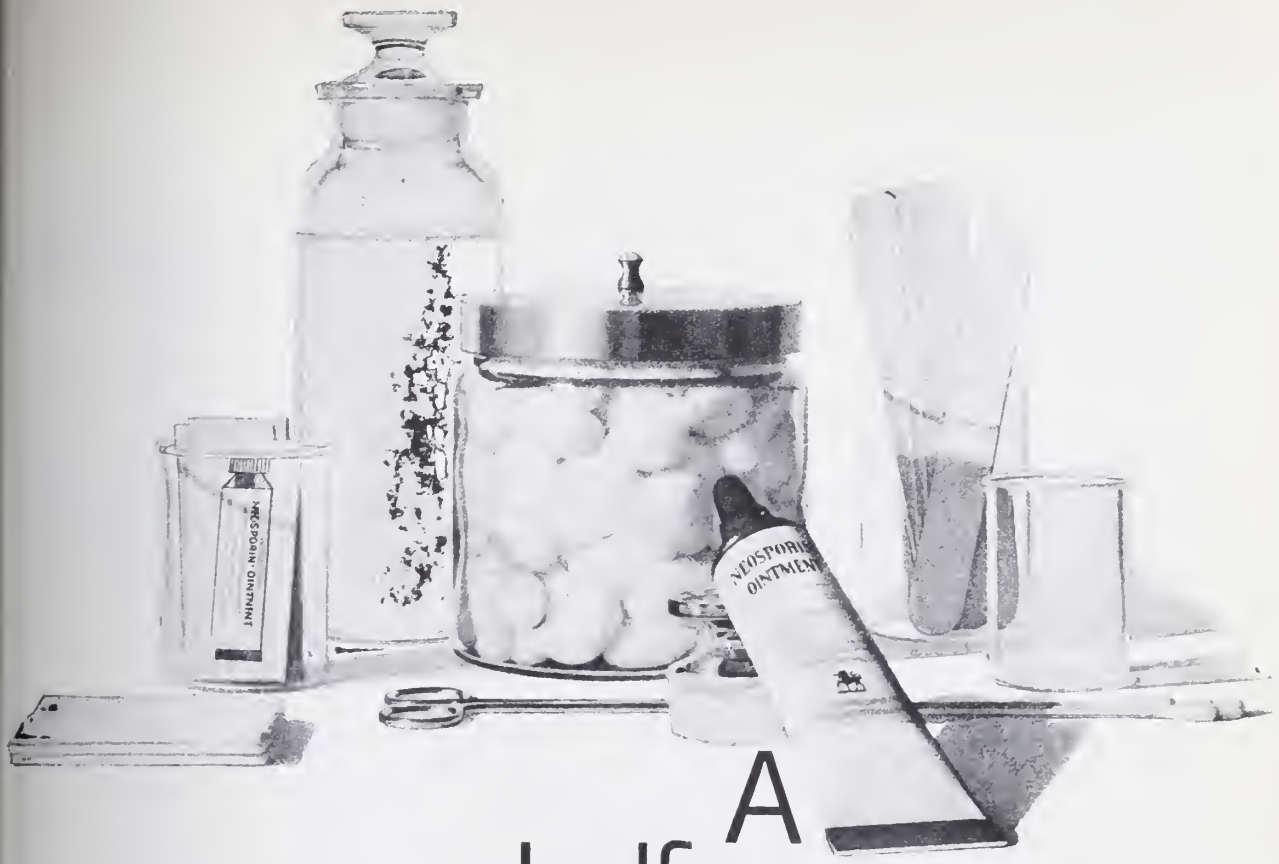
A TAX DEDUCTIBLE BUSINESS EXPENSE

Annual Dues Check Category

REGULAR MEMBERSHIP	SUSTAINING MEMBERSHIP	BUILDER MEMBERSHIP
$50.00	$100.00	$200.00

☐ CHECK ENCLOSED

☐ PLEASE BILL



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

NDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organsms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination n burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of nfection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum s perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

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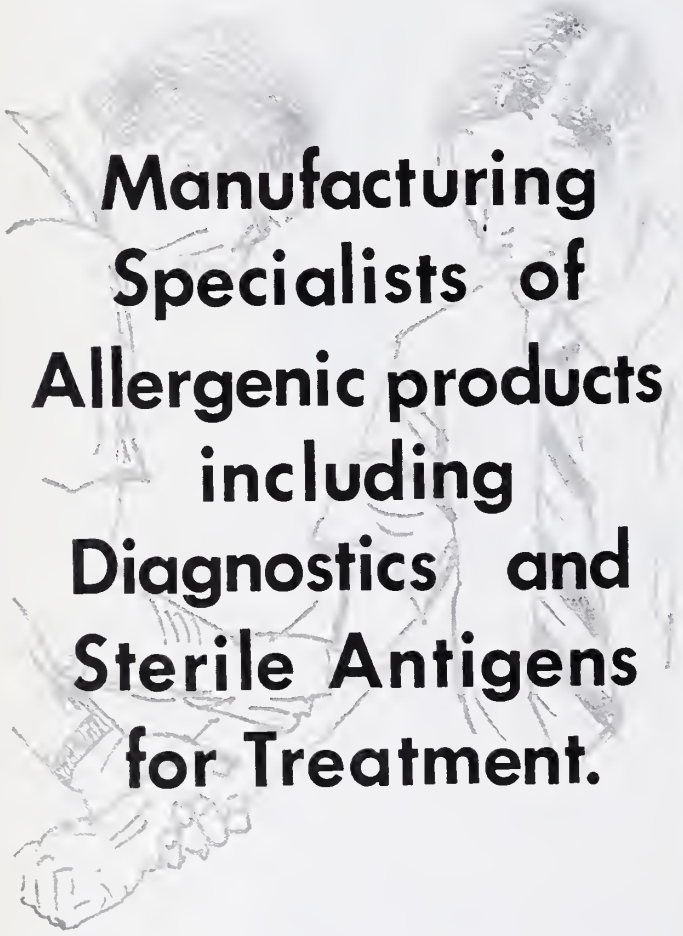

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POMPANO BEACH, FLORIDA 33064

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

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When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Rondomycin® 300 mg. Capsules

[methacycline HCl]

Delivers from the very first dose:

udies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended

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makes sense

For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.

When impetigo goes around help control it with more than an ointment

Neo-Polycin®

zinc bacitracin-neomycin
sulfate-polymyxin B sulfate ointment

the triple antibiotic ointment in a water-miscible base

When used as adjunctive therapy with appropriate systemic treatment, the broad-spectrum coverage of Neo-Polycin is effective against the predominant causative organisms of impetigo—Streptococcus and Staphylococcus.

The unique Fuzene® base is miscible with blood, pus and tissue exudates. Unlike many petrolatum-based ointments, Neo-Polycin does not macerate the skin.

Contraindications: Not for ophthalmic use. Nephrotoxicity and ototoxicity are potential hazards of neomycin. Exercise care in treating burns, ulcerations and conditions where neomycin absorption is possible.

Proper hygiene is important in treating and preventing Impetigo. **Write to Dow Pharmaceuticals, for patient instruction leaflets. Available in English and Spanish.**

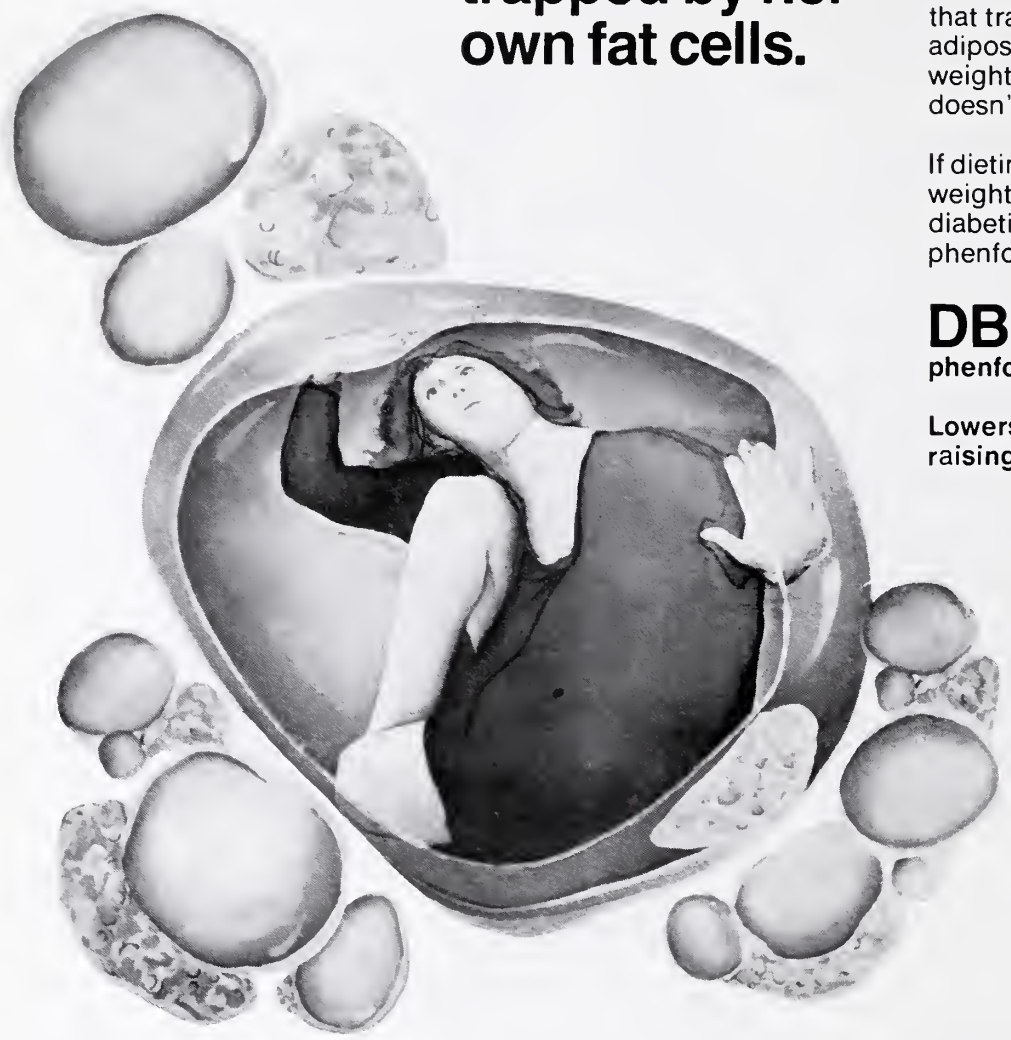
Available in 1 oz., ½ oz., and single application foil packs.

DOW

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, Indiana 46268

The overweight diabetic...

trapped by her own fat cells.



If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the overweight diabetic needs a drug that doesn't stimulate insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD,® phenformin HCl.

DBI-TD® Geigy
phenformin HCl

Lowers blood sugar without raising blood insulin.

DBI® phenformin HCl **Tablets of 25 mg.**
DBI-TD® phenformin HCl
Timed-Disintegration
Capsules of 50 and 100 mg.

Indications: Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
Contraindications: Diabetes mellitus that can be regulated by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; a history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease, cardiovascular collapse (shock); after disease states associated with hypoxemia.
Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:
a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.
b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.
d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.
e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.
Pregnancy: Use during pregnancy is to be avoided.
Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-H (8/74)
For complete details, including dosage, please see full prescribing information.

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Sapphire Valley. High in the cool and beautiful Blue Ridge Mountains. Just 45 miles southwest of Asheville's Jetport. You'll enjoy 18 gorgeous championship holes on our new tennis complex. It's your place to be above all. Call collect today (704) 743-3441 or write Alan Bland, Sapphire Valley, Dept FM Sapphire Valley, N. C. 28774

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When the need is for nutritional supplementation with B complex and vitamin C, BEMINAL-500 has what it takes:

- High potency B complex vitamins
- 500 mg. of vitamin C
- No odor
- No aftertaste

Each BEMINAL-500 tablet contains

Thiamine mononitrate (Vit B_1)	25.0 mg
Riboflavin (Vit B_2)	12.5 mg
Niacinamide	100.0 mg
Pyridoxine hydrochloride (Vit B_6)	10.0 mg
Calcium pantothenate	20.0 mg
Ascorbic acid (Vit C) as sodium ascorbate	500.0 mg
Cyanocobalamin (Vit B_{12})	5.0 mcg

Each tablet contains 0.15 mg. saccharin as sodium saccharin.

Each tablet provides the following multiples of the recognized adult minimum daily requirements.

Thiamine mononitrate	25
Riboflavin	10
Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established.

USUAL DOSAGE: *Adults*—1 tablet daily, or as directed

SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100.

Ayerst® AYERST LABORATORIES New York, N.Y. 10017

7411

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

NSN 6505-00-148-6967

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig

Please see prescribing information on facing page.

One contains aspirin. One doesn't.

Darvocet-N® 100
100 mg. propoxyphene napsylate and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JULY, 1975 • VOLUME 62 • NUMBER 7

PROCEEDINGS

One Hundred First Annual Meeting—Florida Medical Association, Inc. Bal Harbour, April 23-27, 1975

President's Address

THAD MOSELEY, M.D.

Mr. Speaker, Mr. Secretary, Mr. Vice President, Mr. Past President, Dr. Astler and other honored guests. The Florida Medical Association is in a period of crisis. The crisis has helped us for we will be stronger for it. I regret that in years to come I will be remembered as the President who raised your dues and the President who served during the professional liability insurance problem. Now, I wish to tell you of the positive things that have been accomplished this year for this has been a fruitful year. It has been a year of membership participation; a year which has made me proud of the FMA membership.

I was pleased to have been made your President-Elect in May 1973. Through that year I became increasingly aware of the complexity of this organization and of the demands on your President. In May 1974 I became your President and since then I have used all my energies to promote you as physicians and the Florida Medical Association as our organized representative.

Each of us tries to leave behind a better place to live, a stronger organization, a little something of himself as he retires from elected responsibilities and I am no exception. Time will tell if this has been such a year. I want you to know of a portion of the efforts made in your behalf by many persons during this past year.

Your committee for involvement of the membership had an open forum meeting during the 1975 Leadership Conference. With your thoughts and suggestions in mind they have brought through the Board of Governors their suggestions for your consideration and vote.

A similar open discussion session with the Committee of County Medical Society Presidents gave your county society leadership and opportunity to bring their problems before their peers. These discussions have been considered by your Board of Governors and are incorporated into its report to you.

President Thad Moseley, M.D., of Jacksonville, delivers his Presidential Address.

The Legislative Council and Committee have had a busy year. They have placed before you a positive program with two major objectives: the one, a change in the statutes which we hope will help to control the rising cost of professional liability insurance; the other, a presentation of legislation to create a separate Department of Health Services. These goals can be achieved eventually if each of you support the concepts at your local level and if each of you will logically convince your own elected representatives of the need for such legislation. Of lasting significance to Florida medicine was the coming together of the specialty groups, the Chairman of the Legislative Council and the Chairman of the Council on Specialty Medicine to develop an orderly method for working together on legislative projects.

Your Council on Medical Economics completed a fee evaluation study and has filed a petition for a hearing with the Chief, Bureau of Workmen's Compensation, Department of Commerce, in an effort to establish a new fee schedule. The Relative Value Studies Committee has ready for publication an updated relative value schedule. Blue Shield will now accept five digit coding on Medicare reports. The Insurance Committee is evolving a philosophy that will permit a common review of all carriers by a peer review organization developed under the Florida Foundation for Medical Care. The FMIT Committee has reviewed psychiatric coverage with the invaluable help of the psychiatrists in the state and the purchasers of these policies have been asked if such coverage should be included on the policy.

The Council on Specialty Medicine has served as a consulting group, offering advise to all programs of the Florida Medical Association. It now has direct representation on the Relative Value Studies Committee and Legislative Committee. These committees need input from the specialty groups if they are to perform in our best interest. This participation has helped communications with the specialty groups and has been valuable to the FMA Board of Governors. I believe this expanded role for the Council on Specialty Medicine is essential as third party efforts to control the practice of medicine increase.

Your Scientific Council has received the usual approval from the AMA for certification of educational programs within our state and has started the process of inspection with Halifax General Hospital, the first institution to be approved. Sarasota was surveyed early this month—a first for a county. The scientific program arrangements for the 1975 Annual Meeting were completed in January—a most remarkable feat—and you have available at this meeting 22 hours of excellent continuing medical education to help you meet your mandatory requirements.

In a period of rising costs and decreasing advertising income, Dr. Clyde Collins has maintained his enthusiasm and, on a limited budget, has given us, with good grace, the best possible state medical journal. Clyde, relinquishing his job this year after five years as Journal Editor, has done an extraordinary job and deserves the thanks of each one of us.

For us to have credence at any level of activity, we must have the support of those in the allied professions and those with interests in voluntary health programs. These are our natural allies as we pursue the common goal of providing education and care for the people of the State of Florida. Committees assigned to these areas have maintained communication and dialogue with these organizations and have solicited support for FMA efforts of common interest.

The new Council on Medical Systems has developed a statewide Professional Review Program under the Florida Medical Foundation. This will provide educational opportunities for physicians and hospital personnel. It will give us a central source for the development of norms of care and a system for collection and storage of those data necessary for prescribed review. This organization is for the physician and, more important, these data are controlled by the physician. It is my hope that we can meet and even exceed the norms for patient stay, care, and disposition established by the federal government. Negotiations are now under way for the mechanisms to provide a review for the state Medicaid program. This group of physicians has experienced a difficult year as they have defined their functions and as we have experienced the frustrations of working under the regulations of government legislative programs. Dr. James Borland and his committees are to be commended.

The continued problem of PLI as it has changed from day to day has been a frustrating experience for the administration and for your Board. The problem is not solved and will be with us. All physicians are involved as the search for a reasonable solution is going on. It is imperative that you maintain an interest and continue your involvement.

Your Board of Governors has worked to carry out your wishes as expressed by the House of Delegates in the 1974 session. They have carefully reviewed all the efforts I have just discussed and have participated in the deliberations leading to development of these programs. These efforts are summarized in the Board of Governors report which is contained in your delegates packets for this 1975 session.

Many people have made possible the FMA program for 1974-75 and to each I acknowledge my debt and express my gratitude. I do not know what the future holds for medicine. I frequently ask myself the question, and find I have no answer. I do know that the Florida Medical Association will be stronger in the future because of the many physicians who believe in it. I also know that the most lasting contribution of this year will be the continuing leadership and influence of the men, some experienced, but many with responsibility for the first time, who have served you at all levels of FMA structure.

Despite the trials and tribulations of this year, it's been a good year. It has been a year that I will remember, not because of PLI but because of you. I am proud to have been your President.

These gentlemen all share the distinction of having been President of the Florida Medical Association. Having gathered for their annual breakfast, they are (front row, left to right): Warren W. Quillian, M.D., Coral Gables (1963); Leo M. Wachtel, M.D., Jacksonville (1960); William C. Roberts, M.D., Panama City (1957); Walter C. Jones, M.D., Miami (1941); Jere W. Annis, M.D., Lakeland (1958); and Ralph W. Jack, M.D., Miami (1959). Back row: William J. Dean, M.D., St. Petersburg (1972); George S. Palmer, M.D., Tallahassee (1966); W. Dean Steward, M.D., Orlando (1967); H. Phillip Hampton, M.D., Tampa (1965); Samuel M. Day, M.D., Jacksonville (1964); Henry J. Babers, M.D., Gainesville (1969); James T. Cook Jr., Marianna (1970); and Jack Q. Cleveland, M.D., Coral Gables (1968).

General Session

The General Session of the 101st Annual Meeting of the Florida Medical Association was called to order at 11:10 a.m. on Friday, April 25, 1975 in the Medallion Room of the Americana Hotel, Bal Harbour, Florida, by President Thad Moseley, M.D.

Dr. Moseley read a telegram from Mrs. Jean Zellner, widow of one of our Past Presidents, Dr. Robert Zellner of Orlando, who died early this year. Mrs. Zellner expressed her appreciation for the memorial resolution which was sent to her by the Board of Governors. Those in attendance at the General Session were asked to rise for a moment of silent prayer in memory of Dr. Zellner.

Dr. Moseley introduced the persons seated at the head table, after which he announced the winners of the awards for scientific exhibits.

1975 Scientific Exhibit Awards

FIRST PLACE: James R. Jude, M.D., Irwin B. Borucchow, M.D. and Ramanuja N. V. Iyengar, M.D., Miami: "Cardiac Pacemakers"

SECOND PLACE: Bernard H. Cohen, M.D., Leonard A. Lewis, M.D. and Sorrel S. Resnik, M.D., Miami: "A Simple Mechanical Approach to Pseudofolliculitis Barbae"

THIRD PLACE: Manuel Viamonte Jr., M.D. and Maria Viamonte, M.D., Miami: "Anti-Smoking Exhibit"

HONORABLE MENTION: R. R. Sankey, M.D., D. D. Watson, M.D., P. J. Kenny, M.D., and A. J. Gilson, M.D., Miami: "Non-Invasive Cardiac Evaluation with Radionuclides"

Homer D. Kirgis, M.D. and C. Harrison Snyder, M.D., Ochsner Clinic, New Orleans: "The Evaluation and Treatment of Hydrocephalus"

Donald Hansard, M.D., Charles Bianco, M.D., George Bank, M.A. and Charles Williams, M.D., Tallahassee: "Computerized Axial Tomography of the Brain"

Henry Menn, M.D., Miami: "Mohs Chemosurgery for the Treatment of Recurrent Cancer of the Skin"

Mutaz B. Habal, M.D., Gainesville; "Silicone Subdermal Implants for Facial Reconstruction"

Dr. Moseley recognized Dr. Yank D. Coble Jr., Vice Chairman of the Continuing Medical Education Committee and commended him on the excellent job he had done in planning the scientific program for the meeting.

Mrs. Ray E. Murphy and Mrs. Eugene G. Peek presented a check in the amount of $10,621.25 to the President of the Florida Medical Foundation, Dr. Moseley. This contribution represented funds raised for the Foundation by the Woman's Auxiliary during the year.

Dr. Moseley recognized C. Rollins Hanlon, M.D., Director of the American College of Surgeons, Chicago, who was invited to present the annual Baldwin Lecture.

Dr. Hanlon spoke on the topic, "Medicine Today, Medicine Tomorrow," discussing medical education which produces medical manpower today. Dr. Hanlon mentioned that the problem of foreign medical graduates is a pertinent one and one that defies an easy solution. He discussed graduate medical education and the various mechanisms established to control facets of medical education, such as the Association of American Medical Colleges and the Coordinating Council on Medical Education. Dr. Hanlon stated that the profession is concerned with the overall health of the American public and with the importance of good health in achieving individual self-realization, and the collective forward movement of this great American body. "We have the finest medical care system the world has ever known," he continued, "however, there are deficiencies in this system as there will be in all human institutions made up of fallible human beings." Dr. Hanlon encouraged that each of us should strive to act rationally at all times. Dr. Hanlon closed by stating that doctors are strong individualists who must display at all times a dignity and sincerity of responsibility which must characterize a great and honorable profession in service for our fellow man.

Dr. Moseley adjourned the General Session at 12:00 noon.

First House of Delegates

The First House of Delegates convened at 4:45 p.m. on Wednesday, April 23, 1975, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Dr. Louis C. Murray, speaker of the House, presiding.

The invocation was given by Dr. Warren W. Quillian Sr., Past President, Coral Gables, Florida.

Dr. Clarence M. Gilbert, Chairman of the Credentials Committee reported that a quorum of 177 delegates were present and that enough counties were represented to present a quorum. Dr. Gilbert moved that the delegates be seated. The motion carried.

Major C. W. Keith, Director, Division of Driver Licenses, Department of Highway Safety, State of Florida, was invited to the podium for a special presentation to Dr. Francis T. Holland of Tallahassee. Dr. Holland was presented a resolution of appreciation for the twenty-two years of service to the state as Chairman of the Medical Advisory Committee to the Department of Highway Safety and Motor Vehicles, and for all his efforts toward improving highway safety in the State of Florida. Dr. Holland received a standing ovation from the House.

Major C. W. Keith, Director of the Florida Division of Driver Licenses, presents a citation to Francis T. Holland, M.D., Tallahassee, for his 22 years of service as Chairman of the Medical Advisory Committee to the Department of Highway Safety and Motor Vehicles.

Delegates

ALACHUA—O. Frank Agee, Henry J. Babers, George J. Caranasos, Stanley I. Cullen, William B. Deal, Arthur A. Mauceri.

BAY—B. Phillip Cotton, John Mason.

BREVARD—Lewis Bean, James E. Carter, Michael J. Foley, T. John Kaminski, Pat B. Unger.

BROWARD—M. J. Bielek, R. J. Brennan, B. B. Burgess, A. S. Capi, R. B. Carson, B. A. Dobbins, T. W. Hahn, J. A. Jordan, W. B. King, R. E. Murphy, F. B. Ott, J. B. Perry, T. F. Regan, D. M. Seropian, N. J. Skaja, R. E. Talley (Absent—R. L. Andreae, C. H. Bechert, L. A. Erdman, F. G. Gieseke, D. C. Lane, W. D. Wells).

CAPITAL—R. P. Johnson, N. H. Kraeft, J. W. MacDonald, R. N. Webster.

CHARLOTTE — (Absent — Melvyn Katzen, Charles Wilson).

CITRUS-HERNANDO—W. Randall Jenkins.

CLAY—Laurin G. Smith.

COLLIER—William Bailey, Fred Butler.

COLUMBIA—Frank E. Adel.

DADE—Jerome Benson, Jerome Block, Rufus K. Broadaway, Richard C. Clay, Jack Q. Cleveland, Vincent Corso, O. William Davenport, Joseph Davis, Richard Dever, J. Lee Dockery, Charles Dunn, Isaac Egozi, Franklin J. Evans, A. Fernandez-Conde, Joseph Fitzgerald, Ivor Fix, Richard Fleming, L. Marshall Goldstein, Pedro J. Greer, Julian Groff, Leo Grossman, Joseph Harris, Stanley Holzberg, Walter C. Jones III, James Jude, Robert Katims, Harold Kaufman, Warren Lindau, Carlos Llanes, Ronald Mann, Bruce Miller, Stanley Mitchell, Miguel Mora, Thomas Noto Jr., Robert J. Schiess, Daniel Seckinger, Janice Sherwood, Everett Shocket, Chauncey M. Stone Jr., Mario Stone, S. Peter Stokley, William Straight, Maynard Taylor, John Turner, Thomas B. Turner, Edgar W. Webb, Robert Willner, Sheldon Zane (Absent—Pedro Arroyo, Manuel Carbonell, Francis Cooke, John Cunio, Marshall Hall, Herbert Kaiser, Banning G. Lary, Maurice Laszlo, Rose London, Charles A. Monnin, Julian A. Rickles, Walter W. Sackett Jr., Ruth A. R. Simons, Charles Tate).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Warren M. Barrett, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Wilbert L. Dawkins Sr., Joe C. Ebbinghouse, Emmet F. Ferguson Jr., William J. Garoni Jr., William T. Haeck, Charles P. Hayes Jr., Rohert K. Middlekauff, Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander, William D. Walklett (Absent—John C. Kruse).

ESCAMBIA—Eric F. Geiger, Philip B. Phillips, W. M. C. Wilhoit, Henry M. Yonge (Absent—C. Fenner McConnell).

FRANKLIN-GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Richard Connar, Irving M. Essrig, John C. Fletcher, Carlisle Hewitt, Victor Knight, Thomas E. McKell, Ralph M. Stephan, William W. Trice (Absent—Richard S. Hodes, Joel Mattison, Harold L. Williamson).

INDIAN RIVER—Broadus F. Sowell (Absent—James E. Copeland Jr.).

LAKE—B. F. Brokaw, Thomas Weaver.

LEE—Larry Garrett, F. Lee Howington (Absent—Stewart Hagen III).

MADISON—(Absent—William J. Bibb).

MANATEE—John D. Lehman (Absent—John L. Knowles, Millard P. Quillian).

MARION—Henry L. Harrell Sr., C. Brooks Henderson.

MARTIN—Richard Q. Penick, John F. Powers.

MONROE—Jerrold J. Weinstock, William M. Whitley.

NASSAU—Cecil B. Brewton.

OKALOOSA—William W. Thompson (Absent—Edmund R. Kielman).
ORANGE—Norman F. Coulter, William F. Eckbert Jr., Edward L. Farrar Jr., Clarence M. Gilbert, Paul C. Harding, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, Franklin G. Norris, Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo (Absent—Lester C. Nunnally).
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Vernon B. Astler, Curtis W. Cannon, George L. Ford, J. Russell Forlaw, Doris E. Lake, Charles Metzger, Richard B. Moore, Reginald Stambaugh, Dick L. Van Eldik, Howard Willson (Absent—Jerry F. Cox).
PANHANDLE—Herbert E. Brooks (Absent—William F. Brunner).
PASCO—M. L. Saperstein.
PINELLAS—Charles K. Donegan, Irwin L. Entel, John M. Hamilton, Walter W. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, Dacid T. Overbey, James M. Siem, Richard C. Trump, Walter H. Winchester, Rowland E. Wood.
POLK—Sam J. Barranco, Marvin G. Burdette, John W. Glotfelty, W. E. Manry Jr., Frank Zellner Jr. (Absent—T. M. Caswall, J. G. Converse).
PUTNAM—(Absent—Cbarles E. Barrineau).
ST. JOHNS—W. Wayne O'Connell.
ST. LUCIE-OKEECHOBEE—H. C. McDermid.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas R. Murphy, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—Clyde Meade (Absent—John Johnson).
SUWANNEE-HAMILTON-LAFAYETTE — (Absent—Hugo F. Sotolongo).
TAYLOR—John H. Parker Jr.
VOLUSIA—Thomas W. Ayres, O. B. Bonner, James A. Carratt, Richard W. Snodgrass, Thomas L. Wells.
WALTON—Howard Currie.
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER OF THE HOUSE—Charles J. Kahn.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates, and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at *each meeting* of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 17 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee must have a sponsor present before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available at the Reference Committee meetings when they convene. Only the 'resolved' portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk on the morning of the day the Second House of Delegates meets in the afternoon. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I —Green
REFERENCE COMMITTEE NO. II —Buff
REFERENCE COMMITTEE NO. III—Blue
REFERENCE COMMITTEE NO. IV—Pink
REFERENCE COMMITTEE NO. V —Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented to the House, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Louis C. Murray, Speaker
House of Delegates
Charles J. Kahn, Vice Speaker
House of Delegates

The following correction was made in the Proceedings of the 1974 House of Delegates, as published in the July 1974 issue of the Journal of the Florida Medical Association: In the Board of Governors report concerning recommendations of the Council on Specialty Medicine, Page 542, the paragraph subtitled "Pronouncement of Death" should read—"The Board adopted the following resolution of the Florida Neurosurgical Society regarding pronouncement of death in hospitalized patients:

RESOLUTION REGARDING PRONOUNCEMENT OF DEATH IN HOSPITALIZED PATIENTS

"RESOLVED, When a patient is confined to a hospital or an organized nursing home and a physician is or has been in regular attendance on a patient whose medical condition has been deteriorating steadily, with no expectation of reversal of the moribund state, and where death is anticipated for some hours, days or weeks beforehand;

it shall be considered appropriate medical practice to assume the fact of death on the cessation of vital signs when this observation is made by a qualified member of the health team, such as a registered nurse, or a properly qualified physicians assistant, who has been assigned such duties by the organized medical staff. It shall be deemed proper to use this information as the basis for executing the certificate of death as required by State law. This resolution is not meant to apply in the case of a sudden and unexpected death where the physician, himself, may need to be present to question all involved personnel, and to refer to records to form a basis for his decision in regard to the certification of death."

A motion carried to approve the minutes of the 1974 House of Delegates as corrected.

A motion carried to approve the minutes of the Called Meeting of the House of Delegates held December 21, 1974, published in the Journal of the Florida Medical Association in February 1975.

Dr. Murray, the Speaker, advised that during the past year a number of FMA members departed this life and that among these were two past presidents, Joseph S. Stewart, M.D. and Robert E. Zellner, M.D. In memory of these physicians roses have been placed in the vases at each end of the Speaker's podium. Dr. Murray asked the House to observe a moment of silent prayer out of respect and memory of these doctors who have passed on.

The Speaker introduced the officers of the Association: Drs. Thad Moseley, President; Vernon B. Astler, President-Elect; Joseph C. Von Thron, Immediate Past President; Irving M. Essrig, Vice President; James W. Walker, Secretary-Treasurer; and Charles J. Kahn, Vice Speaker.

Dr. Walker, the Secretary-Treasurer, advised the House that Dr. W. Harold Parham, Executive Vice President of the Association, was not present for the First House of Delegates as it was necessary for him to appear in court regarding the hearing on professional liability insurance. Dr. Walker stated that this was only the second time he had missed a meeting of the House in 26 years—the other was when he was serving our country in Korea.

The Speaker then instructed the House.

Remarks of the Speaker

President Moseley, Officers, Delegates, and Members of the Florida Medical Association. This House of Delegates here assembled has been elected to represent our 10,000 physician members in the State of Florida, and must work together in this crucial year in shaping policy that will affect every man, woman, and child in this state, particularly in regard to the crisis concerning professional liability insurance. It is hoped by all that the decisions we make here will contribute in a meaningful way to a solution of this most important problem and thereby help to ensure the continuation of the practice of medicine in an environment free from fear of financial ruin and hopeful that we can thereby assist in keeping the cost of medical care within reach of all of our citizens, within the framework of our time-honored and time-proven system of private medical care under the free enterprise system. We must work diligently to see that our solutions are developed with a spirit of unity, since great strength of purpose is needed to implement our policies, and such strength of purpose will not be achieved without unity. The Resolutions in your handbook have been prefiled and referred to the appropriate Reference Committees, and all additional resolutions received prior to noon today will be given appropriate assignment. It is therefore of utmost importance that you as delegates and members attend the Reference Committee meetings in order to give adequate expression to your positions and views so that the recommendations developed will closely approximate the feelings of this House when presented for final debate during the last two sessions. The importance of your final decisions cannot be overestimated. Your Speaker, Vice Speaker and Officers stand ready to assist in any way. But always be mindful of the fact that the final decisions on policies of this Association are in your hands. Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. Murray introduced Mr. Jack W. Herbert, President, Blue Shield of Florida; E. Charlton Prather, M.D., Director, Division of Health; Mrs. Howard Liljestrand, President, Woman's Auxiliary to the American Medical Association; Mrs. C. Herbert Gilliland, Chairman of the Community Health Council, Woman's Auxiliary to the American Medical Association; Mrs. C. Brooks Henderson, President-Elect, Woman's Auxiliary to the Florida Medical Association; and Mrs. Ray E. Murphy Jr., President, Woman's Auxiliary to the Florida Medical Association. Mrs. Murphy was invited to make a few remarks.

Mrs. Murphy introduced Mrs. Linus W. Hewit, Southern Regional Vice President of the Auxiliary to the AMA. Mrs. Murphy summarized the accomplishments of the Auxiliary during the past year, stating that special emphasis had been put on membership, legislation, Flampac, AMA Education Research Foundation, health careers, health education, and public relations.

Dr. Murray, Speaker of the House, advised that there are corrections in the handbook for delegates as follows: In the report of the Council on Specialty Medicine, on Green page I-11, line 11, the word "PSRO" should be "PMUR." Also, on page 11 of the handbook the total number of delegates listed should be 239 instead of 237.

The Speaker then introduced James Urban, Esq., President of the Florida Bar Association and

asked him to come to the podium to make a few remarks.

Mr. Urban remarked that the medical malpractice crisis is a major one with no simple cause and no simple solution. He stated that he was pleased that leaders of the Florida Medical Association and the Florida Bar have been working together toward a solution to the problem and encouraged the continued cooperation of these two Associations.

The Speaker, Dr. Murray, announced that "the year 1974 was a red letter one for the Florida Medical Association because it was the year of FMA's Centennial Anniversary. I think it was coincidental but very appropriate that as 1974 drew to a close the membership of the Florida Medical Association reached 10,000 for the first time in history."

Dr. Murray further advised that the 10,000th member is Dr. Nieves Maria Zaldivar of Dade County Medical Association. Dr. Zaldivar was asked to come forward to be recognized. She was escorted to the podium by Dr. Pedro Greer at which time she expressed her appreciation for the recognition.

Dr. Murray then presented the President, Dr. Thad Moseley, who delivered his address to the House (see page 23).

The President's Address was referred to Reference Committee No. III.

The Speaker assumed the chair and announced that the members of the Reference Committees are published in the Handbook. He asked that Andre S. Capi, M.D. be added to No. 2 and that James R. Jude, M.D. replace O. William Davenport on No. 5.

Dr. Murray advised that staff would strive to have a copy of the Reference Committee reports available on Friday so that each delegation may have a copy. He announced that Reference Committee IV and V and their staff assistants would meet immediately after the First House recesses in Westward Room #1. Dr. Murray announced the Chairmen of the Reference Committees, the AMA delegates advisor assigned to each one, and the time and place of each meeting:

Reference Committee No. I—Health and Education
10:00 a.m., Westward Rooms II and V
Henry M. Yonge, Chairman
Rufus K. Broadaway, AMA Delegate Advisor

Reference Committee No. II—Public Policy
10:30 a.m., Pan American Room
Joseph H. Davis, Chairman
Richard G. Connar, AMA Delegate Advisor

Reference Committee No. III—Finance and Administration
11:00 a.m., Medallion Room
John C. Fletcher, Chairman
Samuel M. Day, AMA Delegate Advisor

Reference Committee No. IV—Legislation and Miscellaneous
10:30 a.m., Eastward Room
Sanford A. Mullen, Chairman
Burns A. Dobbins Jr., AMA Delegate Advisor

Reference Committee No. V—Medical Economics
10:00 a.m., Floridian Room
Paul C. Harding, Chairman
Francis T. Holland, AMA Delegate Advisor

The Vice Speaker, Dr. Kahn, advised that if there was no objection reports and resolutions would be assigned as published in the Handbook. No objection was raised. The House's attention was called to the referrals of supplemental reports and resolutions which had been distributed in the Delegates' packets. Dr. Kahn stated that Resolution 75-36 was submitted by Dr. George T. Singleton who is not a member of the House of Delegates and therefore requires a second from a delegate. The resolution was seconded.

The House voted unanimously to consider a resolution presented by Dr. Henry L. Harrell of Marion County Medical Society entitled "Use of the Word 'Physician.'" This resolution was referred to Reference Committee III.

Dr. Kahn asked if there were any additional reports from the floor. There were none.

The Vice Speaker announced that the Blue Shield Annual Meeting would be held at 8:00 a.m., Thursday, April 24 in the Medallion Room and that the AMA Delegates Reference Committee would meet at 9:00 a.m., Friday morning in the Pan American Room.

It was announced that the General Session, Friday, April 25, 11:00 a.m. in the Medallion Room will feature the President's Guest Speaker —C. Rollins Hanlon, M.D., Director, American College of Surgeons, Chicago.

The Vice Speaker advised the House that a Joint Flampac and Woman's Auxiliary luncheon will be held Friday, April 25, 12:15 p.m. in the Bal Masque Medallion Room. The speaker will be Senator Robert J. Dole of Kansas.

The First House of Delegates recessed at 6:00 p.m., to reconvene on Saturday, April 26 at 3:00 p.m.

Second House of Delegates

The second meeting of the House of Delegates convened at 3:16 p.m., Saturday, April 26, 1975, in the Bal Masque Room of the Americana Hotel, Bal Harbour, with Dr. Louis C. Murray, Speaker of the House, presiding.

Dr. Robert P. Johnson of the Credentials Committee reported that 201 delegates were present, constituting a quorum and that 38 counties were represented. Dr. Johnson moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, Henry J. Babers Jr., George J. Caranasos, Stanley I. Cullen, William B. Deal, Arthur A. Mauceri.
BAY—B. Phillip Cotton, John Mason.
BREVARD—Lewis Bean, James E. Carter, Michael J. Foley, T. John Kaminski, Pat B. Unger.
BROWARD—C. H. Bechert, M. J. Bielek, R. J. Brennan, B. B. Burgess, A. S. Capi, R. B. Carson, B. A. Dobbins, F. G. Gieseke, T. W. Hahn, J. A Jordan, W. B. King, D. C. Lane, G. P. Messenger, R. E. Murphy, F. B. Ott, J. B. Perry, T. F. Regan, D. M. Seropian, N. J. Skaja, R. E. Talley (Absent—R. L. Andreae, W. D. Wells).
CAPITAL—R. P. Johnson, N. H. Kraeft, J. W. MacDonald, R. N. Webster.
CHARLOTTE—Melvyn Katzen, Fred P. Swing.
CITRUS-HERNANDO—W. Randall Jenkins.
CLAY—Laurin G. Smith.
COLLIER—William Bailey, Fred Butler.
COLUMBIA—Frank E. Adel.
DADE—W. G. Aten, Jerome Benson, Jerome Block, Rufus K. Broadaway, Manuel Carbonell, Richard C. Clay, Jack Q. Cleveland, Vincent Corso, John Cunio, O. William Davenport, Joseph Davis, Richard Dever, J. Lee Dockery, Charles Dunn, Isaac Egozi, R. W. Elkins, Franklin J. Evans, A. Fernandez-Conde, Joseph Fitzgerald, Ivor Fix, Richard Fleming, L. Marshall Goldstein, Pedro J. Greer, Julian Groff, Leo Grossman, Marshall Hall, Joseph Harris, Stanley Holzberg, Walter C. Jones Jr., Walter C. Jones III, James Jude, Robert Katims, Josephine Kouri, B. G. Lary, Maurice H. Laszlo, Carlos Llanes, Ronald Mann, Bruce Miller, Stanley Mitchell, Charles A. Monnin, Miguel Mora, Modesto Mora, Thomas Noto Jr., Robert J. Schiess, Janice Sherwood, Everett Shocket, Ruth A. R. Simons, Chauncey M. Stone Jr., Mario Stone, S. Peter Stokley, William Straight, Maynard Taylor, John Turner, Thomas B. Turner, J. Vanden Bosch, Edgar W. Webb, Robert Willner, Elliot Witkind, Sheldon Zane (Absent—Harold Kaufman, Warren Lindau, Daniel Seckinger).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Wilbert L. Dawkins Sr., Joe C. Ebbinghouse, Emmett F. Ferguson Jr., William T. Haeck, Charles P. Hayes Jr., Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander, William D. Walklett, John C. Kruse (Absent—William J. Garoni Jr., Robert K. Middlekauff).
ESCAMBIA—Eric F. Geiger, C. Fenner McConnell, Philip B. Phillips, W. M. C. Wilhoit, Henry M. Yonge.
FRANKLIN-GULF—Joseph P. Hendrix.
HIGHLANDS—(Absent—Donald C. Hartwell).
HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Richard Connar, Irving M. Essrig, John C. Fletcher, Carlisle Hewitt, Richard S. Hodes, Victor Knight, Joel Mattison, Thomas E. McKell, Ralph M. Stephan, William W. Trice, Harold L. Williamson.
INDIAN RIVER—James E. Copeland Jr., Broadus F. Sowell.
LAKE—Thomas Weaver (Absent—B. F. Brokaw).
LEE—Larry Garrett, Steward Hagen III, F. Lee Howington.
MADISON—(Absent—William J. Bibb).
MANATEE—Sanford Elton, John D. Lehman, Roger A. Meyer.
MARION—Henry L. Harrell Sr., C. Brooks Henderson.
MARTIN—Richard Q. Penick (Absent—John F. Powers).
MONROE—William M. Whitley (Absent—Jerrold J. Weinstock).
NASSAU—Cecil B. Brewton.
OKALOOSA—David Arrowsmith, William W. Thompson.
ORANGE—Norman F. Coulter, William F. Eckbert Jr., Edward L. Farrar Jr., Clarence M. Gilbert, Paul C. Harding, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, Franklin G. Norris, Lester C. Nunnally, Edward W. Stone, Thomas B. Thames, Robert B. Trumbo.
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Vernon B. Astler, Curtis W. Cannon, George L. Ford, J. Russell Forlaw, Doris E. Lake, Richard B. Moore, Reginald Stambaugh, Arthur Trask, Dick L. Van Eldik, Howard Willson (Absent—Charles Metzger).
PANHANDLE—Herbert E. Brooks, William F. Brunner.
PASCO—M. L. Saperstein.
PINELLAS—Charles K. Donegan, Irwin L. Entel, John M. Hamilton, Walter W. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, James M. Stem, Richard C. Trump, Walter H. Winchester, Rowland E. Wood.
POLK—Sam J. Barranco, Marvin G. Burdette, T. M. Caswall, J. G. Converse, John W. Glotfelty, W. E. Manry Jr., Frank Zeller Jr.
PUTNAM—Charles E. Barrineau.
ST. JOHNS—W. Wayne O'Connell.
ST. LUCIE-OKEECHOBEE—H. C. McDermid.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas R. Murphy, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—Clyde Meade (Absent—John Johnson).
SUWANNEE-HAMILTON-LAFAYETTE—L. V. Radkins.
TAYLOR—John H. Parker Jr.
VOLUSIA—Thomas W. Ayres, O. B. Bonner, James A. Carratt, Richard W. Snodgrass, Thomas L. Wells.
WALTON—(Absent—Howard Currie).
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER OF THE HOUSE—Charles J. Kahn.

The Speaker, Dr. Murray, advised that since a number of physicians had requested information on an update of the contract with Argonaut Insurance Company, the Chair had decided on a point of privilege and requested the Executive Vice President, Dr. W. Harold Parham, to speak to you on this matter.

FMA Professional Liability Insurance Program
Remarks to the House of Delegates
April 26, 1975

By
W. Harold Parham, D.H.A.
Executive Vice President

If you have no objection, I will take a few moments to review the history of the liability program and the development of the actual contract itself. There has been a great deal of unjustified criticism and controversy about the contract.

First of all, the FMA professional liability program began in 1929 with three companies underwriting it, with a master policy and individual certificates issued. Shortly after World War II the companies discontinued honoring this coverage.

In the early 50's—I think it was 1952, when Dr. Sam Day was Secretary-Treasurer—a special committee was appointed, chaired by Dr. Robert Zellner of Orlando, to develop an ideal or model professional liability program for the FMA. This was done, the studies were carried out by Marsh & McClennan and an outline of the program was adopted.

In the early 1960's, the Employers group of insurance companies of Boston agreed to underwrite a program for members of the FMA based on these principles that had been developed. Our committee, insurance consultants, and attorneys negotiated a plan with the Employers; we had a format, but we had no contract with them.

As we moved into the late 60's, a turmoil developed over the program due to Employers' internal management decisions. At this time, Dr. Bob Brennan of Ft. Lauderdale, a physician and attorney, was Chairman of a committee that studied the guidelines of the liability program, and they were developed further. In the summer of '72, these guidelines were taken and put in formal form to be executed by the Employers' group of insurance companies. About the time this draft was completed (this model program was not anything thought up overnight; we consulted with medical societies all over the country, the AMA Law Department, and many experts in this field) and ready for signature by the Employers' Commercial Union of London, a worldwide insurance company, purchased the Employers' group of insurance companies. We were immediately advised that they were withdrawing from writing professional liability insurance coverage in the United States. This meant on December 31, 1972 there would no longer be any coverage for members of the FMA under the sponsored plan.

Your Board of Governors directed me to take the guidelines that had already been developed under the Employers' program and with our insurance consultants, market it in this country. We did. We ended up with three companies that would write this program and take over the coverage January 1, 1973.

We negotiated with the Argonaut Insurance Company of Menlo Park, California, which is totally owned by Teledyne, which owns 126 companies. We negotiated with Continental of North America (CNA of Chicago), and we negotiated with Chubb and Son of New York, which has a subsidiary company called the Federal Insurance Company.

When we completed all of our negotiations, the deviation (reduction in rates) was approximately 10-11%. There was not much difference in any one of the three, and we had selected, and when I say we—the Board of Governors — approved entering into a contract with the Federal Insurance Company, subsidiary of Chubb and Son.

In September of 1972 before the contract had been executed, the President of Argonaut came to see me again and wanted to know what to do to get the business. He understood it was going elsewhere, and I advised we had one problem that had not been resolved with anyone of the three—and that was premium financing. We have physicians that wish to make some type of financial arrangements for large annual premiums. Some of you may know that we have one group of anesthesiologists in Florida whose premium is over a quarter million dollars, which is rather difficult to pay out on January 1.

The Argonaut agreed to the quarterly payment of premium, which was later changed to semi-annual for several reasons, but this is what had developed. The President of Argonaut was in Miami the next day. I flew down and met with him in the office of Argonaut, with Dick Lynch, their Senior Vice President and Gordon Hubbard, who heads our Insurance Department. We further negotiated this one additional change, and I went back to Jacksonville, discussed it with the Board of Governors, and it was decided that this additional advantage would be enough to not pursue the Federal, (which is owned by Chubb and Son) and to select Argonaut (owned by Teledyne) as the underwriter. All three companies were financially stable. I think Argonaut at that time had $400 million in assets. This is what was done.

Now the question about legal counsel. We negotiated with three major companies in the country, we discussed it with the AMA Law Department, and many others, because it tied in with the company that this House of Delegates authorized that we establish, FLAMEDCO and later Harlan-Med., the insurance agency of which this Association owns 50% of the stock. This was then carried to the Assistant Insurance Commissioner, Mr. Tom Brown, gone over in detail to be sure there would not be any question about a captive agency, or all this Mickey Mouse stuff we are getting into now. FMA legal counsel was at the table and participated in the review of this contract prior to signing. So that is how it was done and how it developed.

In late November of 1974, there started to be rumblings about the Argonaut. Primarily, like most insurance companies in the country, it had trouble with its investments, particularly some of them with underwriting, such as the tornadoes and so forth. But at any rate, I learned of a development of the Argonaut, and it is more The Teledyne than the Argonaut. Dr. Henry Singleton of Los Angeles, is Chairman of the Board of Teledyne (and I hear it is a one-man board and one-man operation). I have been advised there are approximately 126 corporations that file one tax return in the name of Teledyne. They can move tax credits. They can move profits and loss back and forth at their will apparently, and the best I can tell, most of it is legal. Some of it is being questioned at the present time. We negotiated a 75% increase in premium rates January 1, 1975 in August, approved by the Board of Governors in October, which the President of Argonaut attended. There was absolutely no problem whatsoever. The program we had was considered a model in the nation. I had been asked to come to several different states and present it.

Then the trouble started. First of all, Dr. Singleton of Teledyne, advised the Chairman of the Board of Argonaut on October 2 (the date given me), we do not need you anymore, I am changing the plans for Argonaut. He was a founder of the company. On the day after Thanksgiving, Mr. Woolery, President of Argonaut, met with Dr. Singleton at the latter's direction. Excuse me, just before that Mr. Woolery was called in with his actuary by Dr. Singleton who wanted to know on the Florida plan how they arrived at 75% increase — was it a straight line or a curve? The actuary said a straight line is appropriate in this type of casualty business. He said put a curve on it and see what you get. It came out to 96%. He said that's what the rate will be or you will be out of there by January 1. We did not know the cause at the time. We just knew there

was a problem. But this is what the President of the company told me himself. Then it went from bad to worse. They got into a problem with New York and elsewhere. Dr. Singleton decided to get out of the professional liability business. So they stopped writing in Massachusetts, insisted on a 200% rate increase in New York, which was done the same way that ours was, Pennsylvania and elsewhere, and so that is how it developed.

On February 1, I was called by the former President of our Senate, Jack Matthews, an attorney in Jacksonville, and he advised he represented the Argonaut Insurance Company and wanted an appointment with me Monday night or Tuesday morning. I knew nothing of what it was about. Tuesday morning (February 4, 1975) he arrived with Mr. Kaufman, who is one of a 60-man law firm in Los Angeles and who represents Teledyne and has for many years. This gentleman said you are going to have a 200% increase March 1 — this was on February 4 — or we are going to cancel every doctor in Florida by March 1. I asked where the 200% increase came from, and obviously he did not know. He said there was a mistake made in your negotiations last year — this is what we are demanding. I asked where is the actuarial data to back it up. To this date we have never gotten it. (Some data later came to our attorneys) Apparently, it was another arbitrary figure pulled out of a hat by Dr. Singleton to get them out of Florida.

Dr. Moseley had two meetings of the Board of Governors on this issue to determine what course to take. Our attorneys were brought in, and our insurance consultants and others concerned. On March 12, a letter went to the 5,800 physicians insured under this program demanding roughly a 95% increase in premiums — 35% payable on April 1 and the balance on July 1, and this is when they broke the contract. Before we could even start moving, they entered into the Federal Court and sued us on numerous charges.

To my knowledge there has not been any breach of contract on our part in any manner, shape or form. But we had to answer the complaint and sought an injunction to buy time until we could ascertain what to do. If we had obtained the injunction, we would have had to post a cash bond perhaps in the amount of one and a half million dollars per month, which Argonaut claims they were losing. This Association does not have one and a half million dollars in cash, so another approach was utilized by the Judge and we obtained a stipulation where both sides approved and a court order postponed the premium increase or cancellation until the March trial date. What came out of the trial? We brought in the former President of the Argonaut; he testified to some of these manipulations by Teledyne. Let me just give you two examples of this, because it is going to bear on what I am going to say about Argonaut's financial stability. Number one, I understand that Teledyne sold some silver mines in Mexico and wanted a tax write-off, so they dumped some Argonaut stock to the tune of roughly $20 million in losses and took it over for their tax advantage. They transferred $35 million in tax credits to Teledyne on a consolidated financial statement that we got the day before we went into court last week. And this goes on and on and on. But anyway, what the Judge has basically ordered is that: 1. The contract would probably be unenforceahle on a 5-year basis. (It would be almost impossible to stay under court supervision to determine what the premium would be next year.) 2. That the individual policy holder did have a policy for this year, and 3. At the rate that was determined and negotiated last year for 1975.

There are two other points. The actuarial studies. This Association has retained an actuary of Peat, Marwick, and Mitchell, of New York, who has been the actuary for the professional liability program for the New York State Medical Society in excess of 20 years, and who was used as a witness in the program in Pennsylvania, which was resolved yesterday. The London Agency in Atlanta retained the actuary which has handled the Georgia Medical Association program for the past 8 years. One of them has testified. We have not had a chance to put the other one on the stand. The first one to testify has made it perfectly clear, in his opinion, that the January 1 rate was adequate for the stability of the program for this year, and would not be any particular problem to the company. He felt that they would make a small profit off it this year even considering the inflationary factor. The other actuary has advised me of exactly the same thing.

This Association is studying and evaluating, and your Board will be considering again very shortly forming a reciprocal, or an insurance trust, or a stock or a mutual company, or seeking another major insurance company to take over this program. The actuaries advised if another took over on July 1, and our legislative package was adopted (except the Limit of Liability, because it was up in the air last week as to the amount and a number of other things) the January 1, 1975 premium rate could be utilized. That January 1 of next year that this legislative package would take care of the inflationary factor of a 15-25% increase, which is built into all of these programs every year for inflation alone. We have to go back to the court on Monday, May 12, and present to the Judge data as to how the FMA program will affect the stability of Argonaut and how does it affect the Florida statutes, which state that a company cannot be forced to do business if it affects its stability.

Mr. Speaker, thank you for allowing me the privilege of the Floor to present these remarks.

Dr. Thad Moseley, President, was asked to present the special guest.

Dr. Moseley introduced Congressman Paul Rogers, Chairman of the House Public Health and Environment Subcommittee of the House Committee on Commerce.

Mr. Rogers indicated to the House that his subcommittee would call in Teledyne and "find out a little more about them." He further stated that he doesn't want to get the federal government involved in the malpractice problem unless it is absolutely necessary. He brought out that the problem is costing the American public 5-10 billion dollars a year because it has necessitated defensive medical practice. Mr. Rogers indicated that if their committee does hold hearings it will be to encourage state action and to simply have a platform that people could look to if they could not handle the problem in sufficient time in their own state.

Mr. Rogers discussed various other problems such as health manpower, the possible need for more medical schools, and the problem of maldistribution of physicians. Mr. Rogers pointed out that the medical profession itself should solve the problem of foreign medical graduates coming into the United States, and not involve the government.

Mr. Rogers further stated that he felt that a

National Health Insurance bill would not pass the Congress this year but that there is a good chance of passing one next year. "I think we should have more health input than tax writing input in a National Health Insurance," Mr. Rogers continued. He stated that it is necessary to design a program which will keep the free enterprise and pluralistic system strong and vibrant. He encouraged the Florida Medical Association House of Delegates, its leadership, and its county medical societies to search for methods of improving the delivery of medical care. He stated that we have the finest system of medical care in the world and with the ingenuity and leadership of our doctors, we can improve it even more. Mr. Rogers closed with, "that's the name of the game —better care for the American people."

The President, Dr. Moseley, assumed the Chair and called for Captain John M. Waters to come to the podium to receive the Distinguished Layman Award.

Capt. John W. Waters of Jacksonville (left), one of the primary originators of Jacksonville's widely known emergency rescue service, receives the third FMA Distinguished Layman award from President Thad Moseley, M.D.

A Resolution Honoring Capt. John M. Waters U.S.C.G. (Ret.)

WHEREAS, Capt. John M. Waters, through many years as an officer of the United States Coast Guard and a public official, has established himself as one of the nation's leading authorities in the field of search, rescue and emergency medical care; and

WHEREAS, Captain Waters served for four years as Chief of the Coast Guard's Search and Rescue Division and later for 18 months assisting the Federal Highway Administration in the establishment of a program of rescue for the nation's highway accident victims; and

WHEREAS, He is the author of four books and more than 50 articles on emergency medical care, safety, search and rescue, and sea warfare; and

WHEREAS, He was a key figure in the late 1960s in the creation of the City of Jacksonville's emergency rescue system, a model program that has been studied by more than 300 groups from other nations, states and cities; and

WHEREAS, Captain Waters has served on the American Medical Association Committee on Emergency Medical Services; the Committee on Trauma of the American Academy of Orthopaedic Surgeons; the Florida Committee on Trauma of the American College of Surgeons; the Jacksonville Council on Emergency Medical Services; the Florida Medical Association Committee on Emergency Medical Services; the Committee on Emergency Medical Services of the National Academy of Science/National Research Council; as a Director of the American Trauma Society; and as President of the Northeast Florida Heart Association; and

WHEREAS, He is the only layman ever to serve as Clinical Professor, Department of Surgery, University of Florida College of Medicine; and

WHEREAS, As Project Manager of the multi-million-dollar Florida Eight Counties EMC Project, Captain Waters directs what is considered to be another model program in the field of emergency rescue; and

WHEREAS, Since September, 1974, Captain Waters has served by appointment of President Ford as one of a five-man advisory committee of citizens to the Interagency Committee on Emergency Medical Services; and as a principal consultant on a National Science Foundation-funded project to develop design of a new heavy rescue vehicle for the National Fire and Rescue Services; and

WHEREAS, Captain Waters continues to serve the citizens of Jacksonville, Florida, as Director of Public Safety, a position from which he played a leading role in establishing the Jacksonville Fire Division as a national leader in emergency medical and rescue services; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association, at its 101st Annual Meeting at Bal Harbour, Florida, April 23-27, 1975, present to Capt. John M. Waters its Distinguished Layman Award.

Captain Waters expressed his pleasure and gratification in receiving the award and briefly discussed his role in the emergency medical services throughout Florida.

Dr. Moseley requested Dr. Richard S. Hodes, M.D. of Tampa to come to the podium escorted by Dr. Harold Williamson and Dr. David Lane, to receive the A. H. Robins Company Award "For Outstanding Community Service by a Physician."

A. H. Robins Company Award

"For Outstanding Community Service By a Physician"

Rep. Richard S. Hodes, M.D., a people-oriented physician-legislator from Tampa, has been elected to receive the 1975 A. H. Robins Company Award for Outstanding Community Service by a Florida Physician.

The award is presented each year to a member of the Florida Medical Association, Inc., who renders distin-

guished public service to his community. Dr. Hodes was selected by the FMA Board of Governors from among several nominees presented by county medical societies.

A native of New York City, Dr. Hodes moved to Florida as a child. He received his B.S. degree in 1944 and his M.D. degree two years later, both from Tulane University. He then took a fellowship at the University of Minnesota prior to establishing his anesthesiology practice in Tampa in 1951.

As a member of organized medicine, Dr. Hodes has served as Vice President of the Hillsborough County Medical Association; a member of the FMA House of Delegates and a member of the Committee on State Legislation of the Florida Medical Association; President of the Florida Society of Anesthesiologists; and on the Board of Trustees of the American Society of Anesthesiologists.

First elected to the Florida House of Representatives in 1966, Dr. Hodes has served in that chamber continuously. For six years he chaired with distinction the Committee on Health and Rehabilitative Services, stepping down this year to accept the chairmanship of the House Education Committee.

As a legislator, Dr. Hodes has played an important part in: establishing funding mechanisms to enhance Tampa General Hospital's position as a major teaching facility in its area; creating the University of South Florida School of Medicine; establishing the Tampa Mental Health Institute; passage of the Community Hospital Education Act; securing funds to expand medical education facilities in Gainesville and funding for the University of Florida School of Dentistry; and establishing a legislative internship program for students.

Dr. Hodes also:

—Participated in the writing of the new state constitution (1968).

—Assisted in the upgrading of the educational system, particularly in the area of funding for exceptional child education (1968).

—Was a member of the House Committee which brought about reorganization of the executive branch of state government (1969).

—Worked with Rep. Maxine Baker in helping to establish the development of the Community Mental Health Act (1969).

—Established the Community Medical Education Act which provided for graduate medical education in community-based hospitals throughout the state (1971).

—Enacted the Juvenile Probation Act which created field services for the management of juvenile delinquents (1971).

—Helped in creating the Child Abuse Registry (1971)

—Succeeded in establishing the Kidney Disease Board (1971).

—Provided funding for additions of Gifted Children's Classroom Units to the Florida School System (1971).

—Established a Coastal Coordinating Council for a continuing program of research in problems relating to the coastline of the state, a measure regarded as model legislation by the National Legislative Conference (1971).

—Succeeded in creating the Comprehensive Family Planning Act (1972).

—Created abortion reform legislation (1972).

—Participated in the Emergency Medical Services Act, which created a state plan for emergency medical services and licensing of ambulance services (1973).

—Assisted with the establishment of the Division of Children's Medical Services (1973).

—Assisted with the establishment of the Comprehensive Health Education Act, which provided for health education programs for children through high school (1973).

—Added epilepsy and cerebral palsy to the Disability Treatment Program of the Division of Retardation (1973).

—Helped obtain funds and program for statewide cervical cancer screening to provide Pap smear tests for women who otherwise might not obtain them (1974).

—Was instrumental in passing the School Health Services Act (1974).

—Helped in creating statewide licensing of day care, which provides for uniform minimum standards for child care facilities (1974).

—Exercised influence in getting the Legislature to call upon Congress to repeal PSRO legislation (1974).

Dr. Hodes is Chairman of the Task Force on Human Resources of the National Legislative Conference and is Chairman of the Board of the Human Services Institute for Children and Families. He was tapped by President Ford to be a participant in the Economic Summit Meeting.

On several occasions Dr. Hodes has testified before congressional committees. Three appearances before House Ways and Means concerned welfare reform, revenue sharing and the hazards of national health insurance.

Before the Senate Finance Committee he has twice testified on social services revenue sharing, and he appeared before the Senate Committee on Oceanography on management of coastal resources.

Dr. Hodes' legislative work has earned for him several awards, including: the Florida Jaycee Good Government Award for outstanding contributions to state government; a citation from the Florida Association for Retarded Children for outstanding legislative contributions in the area of retardation; and the Florida Voluntary Health Association's award for outstanding service.

Twice he was nominated by the St. Petersburg Times and the Capitol Press Corps for the most valuable legislator award

Dr. Hodes expressed his appreciation for the award and stated that without the assistance of the physicians of the state and the legislators that he has worked with he could not have accomplished the goals that have been attributed to him.

Dr. Moseley recognized Mr. Thomas Whitfield, the A. H. Robins Company representative, and expressed his appreciation to the Company for making this award possible.

State Rep. Richard S. Hodes, M.D., Tampa, receives the A. H. Robins Company Award for Outstanding Community Service by a Physician from President Thad Moseley, M.D.

Dr. Moseley then recognized Senator David Lane and Representative John Forbes.

The President, Dr. Moseley, read an announcement from Dr. Norman Vickers of Pensacola advising the House of the recent death of a true friend of medicine. "Mr. Prevost Coulter, a writer and columnist for the Pensacola News-Journal died on April 10, 1975.

"Most of you will remember last year when Dr. Von Thron gave Mr. Coulter, or "Doc" as he was called, the Distinguished Layman's Award at the Centennial Meeting of the 1974 House of Delegates. He has been honored as well by the Escambia County Medical Society for his outstanding reporting on medical affairs and received a special award from the American Medical Association for outstanding medical reporting.

Mr. Coulter leaves two sons and a daughter.

All of Florida Medicine mourns the loss of our friend."

The motion was made and seconded that this announcement be entered into the proceedings of the House of Delegates and a copy of it sent to his family. The motion passed.

The President then recognized the Student AMA Representatives attending the Annual Meeting as follows:

Thomas Bianchi, University of Miami School of Medicine, Miami
Jerome P. Fisher, University of Florida College of Medicine, Gainesville
Jim Sherman, University of South Florida College of Medicine, Tampa

Dr. Moseley requested the Deans of the Medical Schools or their representatives to come to the podium for presentations to the medical schools of unrestricted contributions from the AMA-ERF. Mrs. T. M. Daniel, Chairman, Woman's Auxiliary AMA-ERF Committee, and Mrs. Ray E. Murphy Jr., Woman's Auxiliary President, made the presentations.

Dr. Gerry B. Mendelson, Assistant Dean and Dean for Curriculum, accepted the contribution for the University of Miami School of Medicine in the amount of $5,142.96. Dr. William Deal, Associate Dean, accepted the contribution of $6,231.48 on behalf of the University of Florida College of Medicine. A check for $5,745.30 was presented to Dr. Donn L. Smith, Dean, University of South Florida for the College of Medicine. The President, Dr. Moseley, asked Dr. Francis T. Holland of Tallahassee to take the contribution of $2,735.42 to the Director of Programs in Medical Science of Florida State University.

The Speaker, Dr. Murray, assumed the Chair and called on Dr. Warren W. Quillian Sr. to present two resolutions of special commendation from the Board of Past Presidents.

Resolution From the Board of Past Presidents

A Tribute of Appreciation
to
Thad Moseley, M.D.

Organized medicine in Florida is confronted constantly with problems that test the ability, ingenuity, and training of the officers, Board of Governors, and Council Chairmen selected to make decisions influencing its present condition and future progress. During the past year we have been confronted with unprecedented emergencies involving many phases of our activity. The Board of Past Presidents wishes to commend Dr. Thad Moseley and his staff for efforts directed toward the solution of these problems and for their outstanding labor in our behalf.

Dr. Moseley expressed his appreciation for the commendation.

Resolution From the Board of Past Presidents

A Tribute of Appreciation
to
W. Harold Parham, D.H.A.

We believe that organized medicine in Florida is fortunate to be the recipient of Harold's consistent efforts and professional services. His loyalty, ability, mature judgment, and experience have been acknowledged and respected nationally as well as locally. We take the opportunity on this occasion to thank Harold for his self-effacing endeavors on behalf of the Florida Medical Association.

Report of Reference Committee No. I
Health and Education

Dr. Henry M. Yonge, Chairman of Reference Committee No. I, came forward to present the report of the committee.

Council on Scientific Activities

The Reference Committee proposed the following amendments to the report of the Council on Scientific Activities.

The recommendation of the Reference Committee to more widely and clearly disseminate the information concerning the internal reorganization of the Association as discussed in the first three paragraphs of the report was adopted.

Committee on Continuing Medical Education
Board of Governors Report:
Continuing Medical Education
Resolution 75-3—Continuing Medical Education Requirements
Sarasota County Medical Society
Resolution 75-16—Continuing Medical Education Requirements
Orange County Medical Society
Resolution 75-34—Continuing Medical Education Requirements
St. Lucie-Okeechobee County Medical Society

The Reference Committee indicated that these items were considered together as they all pertain to continuing medical education. The Reference Committee recommended adoption of a substitute resolution for Resolutions 75-3, 75-16, and 75-34.

Substitute Resolution 75-3 was adopted.

Substitute Resolution 75-3

Continuing Medical Education

RESOLVED, That no immediate change be made in the mandatory continuing medical education requirements; be it further

RESOLVED, That the Board of Governors establish some mechanism whereby better communication with local county medical societies be established; be it further

RESOLVED, That the AMA Physician's Recognition Award be encouraged but not be considered as a replacement for the Florida Medical Association continuing medical education requirement at this time, be it further

RESOLVED, That if the FMA continuing medical education program becomes too complicated or costly that the AMA Physician's Recognition Award be reconsidered as a replacement for the FMA continuing medical education requirement.

Upon recommendation of the Reference Committee the item from the report of the Board of Governors entitled Continuing Medical Education was filed for information.

Reference Committee I considered Health and Education. Left to right: Jack W. McDonald, M.D., Tallahassee; Henry M. Yonge, M.D., Pensacola, Chairman; Recorder Marcia Protheroe; Dick L. Van Eldik, M.D., Lake Worth; John W. Glotfelty, M.D., Lakeland; (not shown) John C. Turner Jr., M.D., Coral Gables.

The Reference Committee recommended that a liaison person be appointed to the Community Hospital Education Council by the FMA Board of Governors as indicated in paragraph four under the section pertaining to The Committee on Medical Education. The recommendation was adopted.

Upon recommendation of the Reference Committee the word "facilities" in paragraph six of the section on The Committee on Medical Education, first sentence, was changed to "faculties."

Upon recommendation of the Reference Committee the report of the Council on Scientific Activities was adopted as amended.

Council on Scientific Activities

GEROLD L. SCHIEBLER, *Chairman*

During the Association's 1974-75 year, the Council on Scientific Activities held meetings on July 12, 1974, September 27, 1974, and January 31, 1975.

With the internal reorganization of the FMA, the function of the Committee on Regional Medical Programs was transferred to the Council on Medical Systems. The Council as a body became the Research Committee and the Committee on Scientific Assemblies became a subcommittee of the CME Committee. The Committee on Medical Schools became the Committee on Medical Education with similar program responsibility.

A summary of each committee's activities are summarized in this Council report. Several recommendations of the Council and its Committees were previously submitted to, and acted upon, by the Executive Committee and the Board of Governors. They appear in the report of the latter body.

The Committee on Continuing Medical Education continued its efforts to implement various aspects of the continuing medical education program. The Committee developed a comprehensive document entitled "Policy Provisions Governing the Postgraduate Education Program." This detailed all current policies and their application as they applied to the CME program.

Late in 1973, the Committee was informed that initial accreditation of CME programs, offered by appropriate institutions and organizations, was carried out by the AMA Council on Medical Education through its Advisory Committee on Continuing Medical Education. Upon request by an applicant, such accreditation is based on a site-survey. Because of the volume of requests for accreditation, the AMA Council on Medical Education recommended that each state medical association plan and implement their own program of accreditation, based on procedures adopted and periodically reviewed by the AMA Council. Once local institutions and organizations are approved under a state association program, they are included in the annual list of AMA accredited institutions and organizations. The FMA proposal to develop an accreditation program was submitted to the AMA Council on Medical Education on April 19, 1974. On June 23, 1974, the AMA granted provisional approval to the FMA. To date, the FMA has granted initial accreditation to Halifax Hospital Medical Center in Daytona; and the CME Committee is currently processing the requests for CME accreditation from Sarasota County Medical Society, Broward General Medical Center, and Dade County Medical Association.

FMA Recognized State Specialty Societies have taken advantage of their option to develop their own CME criteria to reflect their members unique educational needs. All of the societies have 1) submitted their own criteria to the Committee on Continuing Medical Education for approval, 2) are in the process of developing their own criteria, 3) or are utilizing the FMA requirements.

A sub-committee of the Continuing Medical Education Committee, under the leadership of Dr. Yank Coble, assumed the responsibility for developing the Scientific Program for the 101st Annual Meeting of the Florida Medical Association. The Committee and Council are very proud of the tremendous job done by Dr. Yank Coble, in having the Scientific Program completed by December 31, 1974. There will be thirty-one (31) scientific program sections, and twenty-five (25) scientific and educational exhibits.

The Committee considered the question of substituting the AMA's Physician Recognition Award for the current FMA continuing medical education requirements. The Committee and Council recommended that such a change not take place at this time because 1) such a change, after one year of the current FMA three-year CME cycle, would create confusion for the membership, 2) there is a need for the FMA to garner more experience with its current continuing medical education program, and, 3) a continuing effort should be made in enhancing the present program. The Committee felt that this subject should be under continuing review—particularly if the current FMA CME program becomes too complicated or costly to continue, or in case federal or state legislation mandates a change in the CME program. If it appears that the FMA should adopt the AMA Physician's Recognition Award, such a program ideally could be implemented at the beginning of the second three-year cycle, i.e., January 1, 1977.

The Committee on Scientific Publications continued to support the publication of a first-class scientific journal, even in the face of rising production costs and declining national advertising revenue. At mid-year, the Editor made drastic cuts in editorial content, to diminish the fiscal losses. As of January 1, subscription rates, classified advertising rates and regional display rates were increased to provide additional revenue to partially meet the challenge of rising costs.

The Editor and the Committee on Scientific Publications have proposed to the Executive Committee that (effective July 1st) national advertising rates be increased by 50 per cent across the board. This increase, coupled with increased support from the general budget of the FMA should allow restoration and enhancement of the scientific component of the *Journal*.

The special Centennial Issue of *The Journal* (January 1974) won one of the top awards in the 1974 Florida Magazine Association competition. That issue took first place in General Excellence for non-profit association publications with less than 20,000 circulation.

The Committee on Medical Education reported that the previous confusion which existed over the relative roles of the previous FMA Committee on Medical Schools and the Florida Joint Commission on Medical Education had been eliminated with the incorporation of their functions in the new Committee on Medical Education.

The "Steering Committee" of the Committee on Medical Education (composed of the Chairman of the Committee on Medical Education and the three Chairmen of the Medical Advisory Committees to the Medical Schools) met on June 22, 1974, with Mr. Jack McGriff, Chairman, Health Advisory Committee, Florida Board of Regents. They discussed the long-range goals and objectives for the University of Florida Medical School. The idea of formulating long-range goals and objectives originated in a conference between Mr. McGriff and Vice-President and Dean Chandler A. Stetson, in which Mr. McGriff asked Dean Stetson to formulate some long-range objectives for the University of Florida's Medical School. Dr. Stetson developed a questionnaire in which he stated questions that he felt needed to be answered before long-range goals and objectives could be docu-

mented. The questionnaire was circulated to members of the 1) University of Florida Medical School faculty, 2) members of the University of Florida Medical School Advisory Committee, 3) officers of the FMA, and 4) to Mr. McGriff. Mr. McGriff felt that he needed the advice of the "Steering Committee" of the Committee on Medical Education before responding to Dean Stetson's questionnaire. Therefore, the "Steering Committee" met with Mr. McGriff to assist him in analyzing and formulating the goals and objectives of the University of Florida's Medical School.

Among the subjects discussed were 1) the medical school's prestige and reputation, 2) excellence of training and teaching, 3) academic programs, 4) faculty, 5) number of medical students, 6) emphasis on family care, 7) research, 8) patient care programs, 9) primary care centers, 10) teaching of the business of medicine, 11) Physician's Assistants, 12) college of medicine as a national and/or regional resource center, and 13) school of optometry.

The Committee on Medical Education met on November 22, 1974, and reviewed with Dr. Kenneth Penrod, Staff Director, Community Hospital Education Council (CHEC), the current law under which the CHEC functions, and how the FMA could develop a closer relationship with the CHEC. As a result of this discussion, the Committee recommended that a liaison person be appointed to the Community Hospital Education Council by the FMA Board of Governors. Such a liaison person could report on a regular basis to the FMA Board of Governors. Other topics considered by the Committee were 1) the new FLORIDA COLLECTIVE BARGAINING ACT and its effect on physician faculty members of the state's medical schools, 2) the current status of the proposed school of optometry, and 3) activities of Physician's Assistants.

The Committee is reviewing the "Fifth Pathway" problems and exploring alternatives for physician faculty members in relation to the FLORIDA COLLECTIVE BARGAINING ACT.

Specifically, the Committee and the Council feel that the medical faculties of the state university system should not be included in any statewide bargaining unit inasmuch as they represent a service group of professionals with marked variance in purpose and vocational activity from other employee groups within the State of Florida. Their inclusion in a large bargaining group would be most detrimental to the current high quality of medical education and delivery of health care to the citizens of our state.

The Council sitting as the Research Committee reviewed eleven grant applications and recommended that they be declined because they were either from 1) investigators who wanted to continue projects for which other funds had expired, 2) investigators requiring funds beyond the ability of the Foundation to provide, or 3) investigators who did not follow grant application guidelines. The Council unanimously felt that they needed to develop new guidelines for the funding of future research projects by the Florida Medical Foundation. The new guidelines will state that priority will be given to grant requests coming from the "private sector," second highest priority to physicians in private practice, working in concert with a physician full-time in an educational unit, and third priority to full-time members of an academic or other educational unit. In the future, the Council has recommended to the Board of Governors that the membership he notified by August 30, through all appropriate publications about 1) the maximal amount of funds availahle for individual research projects, 2) the availability upon request from FMA headquarters of guidelines for developing and processing such applications, 3) that applications for research project grants will be received by the Council on Scientific Activities until October 30, and 4) that every attempt will be made to notify each applicant by January 31, of the decision regarding their request.

Supplemental Report
Council on Scientific Activities

Upon recommendation of the Reference Committee Recommendation No. 1 of the Supplemental Report of the Council on Scientific Activities was adopted.

The Reference Committee recommended that the remainder of the supplemental report be filed for information.

The remainder of the report was filed.

Supplemental Report
Council on Scientific Activities

GEROLD L. SCHIEBLER, *Chairman*

At the January 11, 1975, meeting of the Board of Governors, the Committee on Medical Education, in consultation with the Council on Scientific Activities, was asked to formulate a position on the so-called "Fifth Pathway," or special junior clinical clerkships for U.S. citizens studying at foreign medical schools. Both the Committee and Council recommend the following:

RECOMMENDATION

The Committee on Medical Education recommends that the Florida Medical Association adopt a plan of not accepting the so-called "Fifth Pathway" at this time.

The Committee on Medical Education further recommends that the Florida Medical Association oppose any legislation which would make such an acceptance mandatory.

Council on Specialty Medicine

The Reference Committee recommended that the portion of the report of the Council on Specialty Medicine in the Statement of Policy, Paragraph 3, pertaining to coordination of legislative programs with the Chairman of the Council on Legislation and Regulation and/or the Board of Governors as appropriate, be referred to the Board of Governors for clarification.

This portion of the report was referred to the Board of Governors for clarification.

Upon recommendation of the Reference Committee the word "Mandatory" was deleted from the heading of the paragraph entitled, "Mandatory Pap Smears."

Upon recommendation of the Reference Committee the report of the Council on Specialty Medicine was adopted as amended.

Council on Specialty Medicine

FREDERICK C. ANDREWS, *Chairman*

The Council on Specialty Medicine held three meetings during the past Association year, 1974-75; these being on August 24, 1974 in Orlando, November 16, 1974 in Orlando, and on February 22, 1975 in Orlando. A special Ad Hoc Committee of the Council held meetings on November 16, 1974 and February 22, 1975, both in Orlando. Representatives of the Council met jointly with the Chairman of the Committee on State Legislation on September 18, 1974 in Orlando.

At the writing of this report the Council is composed of 31 recognized specialty groups. The applications of three specialty groups were reviewed by the Council at its February 22, 1975 meeting and submitted to the Board of Governors for approval of recognition. This brings the total number of FMA recognized specialties to 34.

Attendance at all meetings has been exceptionally good, and there has been participation by alternate representatives and also officers of the specialty societies in the deliberations of the Council. The Chairman is grateful for the high interest and cooperation shown by all those who participated in the Council's activities.

The following is a summary of the general activities of the Council throughout the year. All recommendations of the Council have been submitted to and acted upon by the Board of Governors and are included in the Board's report to the House of Delegates.

Functions of the Council—Because of the restructuring of the FMA councils and committees as directed by the 1974 FMA House of Delegates, the Council's role and functions have been expanded to include the following:

1. Liaison between the FMA and recognized specialty groups for the purpose of coordinating legislative programs and activities:
2. Assist the FMA Council on Scientific Activities in:
   a) Development and the on-going review of the continuing medical education requirements for FMA members; and,
   b) Coordination and implementation of the sectional scientific programs at the Annual Meeting.
3. Arrange for the appropriate specialty groups to carry out activities of the Association which relate to hearing, vision, maternal health, sports, medicine and others as may be designated. These functions have previously been under the purview of other Association committees which were eliminated or consolidated under the restructuring of councils and committees.

Legislative Coordination—The Council recognizes the increasing importance that specialty groups coordinate their legislative activities and lobbying efforts with the FMA. As a result, the Council has developed a policy statement which has subsequently been approved by the Board of Governors establishing guidelines to be followed by specialty groups in conducting legislative activities. The Council feels that these guidelines will enhance the cooperative working relationship between the FMA and the specialty groups in legislative activities and ultimately the success of legislative goals.

STATEMENT OF POLICY

1. It is essential for the FMA to develop a program of legislative activity that will provide the necessary and appropriate role for FMA recognized medical specialty groups in their relationships with the Legislature.
2. Periodically FMA recognized medical specialty groups will have interests and concerns that are specific to them and not necessarily of major interest and concern to the FMA as a whole.
3. Those specialty groups with particular interests and concerns should have the privilege of developing legislative programs of their own, provided that these programs are not in conflict with FMA policy and provided that these programs are coordinated with the Chairman of the Council on Legislation and Regulation and/or the Board of Governors as appropriate.

[REFERRED TO BOARD OF GOVERNORS FOR CLARIFICATION]

4. The Chairman of the Council on Legislation and Regulations in consultation with the Chairman of the Council on Specialty Medicine shall develop a set of guidelines, subject to approval by the Board of Governors, to govern the details of the legislative activities of the specialty groups. These guidelines may be modified by the Chairman of the Council on Legislation and Regulations or Chairman of the Council on Specialty Medicine from time to time as experience and circumstances dictate provided that there is agreement by the other Chairman and approval by the Board of Governors.
5. The Council on Specialty Medicine shall develop appropriate guidelines to assure coordination of the legislative activities of the FMA specialty groups.

The Council has received detailed reports on the FMA legislative program priorities at each of its meetings and has continually urged that each specialty group do whatever possible to assist. In particular, each specialty group President has been requested to write a letter to each member of the Florida House and Senate asking their interest and cooperation in solving the Professional Liability Insurance dilemma.

Pap Smears—The Council has expressed its support for a recommendation of the Florida Society of Pathology to endorse a program whereby all members of the FMA be urged to offer a cervical, vaginal pap test on all females twenty years of age and over, or at risk, admitted to a hospital who have not had this test in the past year. This is not a mandatory procedure, but strictly voluntary. (The Board disapproved the recommendation for endorsement.)

Limited Learning Disability—The Council has under review Resolution #74-30, Limited Learning Disability, which was referred for further study by the 1974 House of Delegates. This resolution has also been under study by the School Health Medical Advisory Committee who will present a statement to the Council at a future meeting.

Vocational Rehabilitation—The Council reviewed a letter pertaining to recent Federal Vocational Rehabilitation regulations which had been promulgated regarding the diagnosis and treatment of mental disorder by licensed psychologists. It was the Council's opinion that the Florida Division of Vocational Rehabilitation should continue its established practice of diagnosis and treatment of mental and emotional disorders by physicians. A resolution to this effect was adopted by the Council and submitted to the Board of Governors.

Medical Service Programs by Lay Groups—The Board of Governors requested that criteria be established for granting endorsement by FMA for medical service projects by lay groups. An Ad Hoc Committee was appointed for this purpose and a set of criteria has been recommended. The Council has reviewed the criteria and has recommended its adoption. The criteria provides for approval by local county medical societies, medical supervision and adequate reporting of findings.

Criminal Acts and Psychiatry—There has been concern expressed that law and order could not be adequately maintained unless persons charged with criminal offenses and who have pleaded insanity, be tried for criminal acts first, judgment rendered, and then opinions expressed as to the degree of insanity which played a part in the commission of a crime. This matter had been previously

reviewed by the Committee on Mental Health and the Florida Council of District Branches of the APA. The Council has recommended to the Board of Governors that a task force be appointed composed of representatives of the FMA and the Florida Bar, and that this task force study this problem and develop recommendations for their parent organizations and the Legislature.

Health Insurance Contracts-Mental Disorder Coverage—Representatives of the Florida Council District Branches of the APA had expressed its concern to the Council with regard to the matter of unfair discriminatory provisions for the treatment of mental disorders in health insurance contracts. The Council has expressed its support for efforts of the Florida Council of District Branches in seeking to eliminate this discrimination.

Steering Committee—Because of increasing size of the Council and also its assumption of many of the activities which have been under the purview of other councils and committees, the Council considered the establishment of a Steering Committee in order to have more indepth study of matters coming before the Council. At its February 22, 1975 meeting, the Council rescinded its previous action approving such a committee by abolishing the concept of a Steering Committee.

School of Optometry—The Council reviewed studies currently being made as a result of recently enacted legislation establishing a School of Optometry in the state. These studies include the possible location of the school, cost of promulgation, and its degree of affiliation with the existing medical schools. The Council has recommended to the Board of Governors that the Florida Society of Ophthalmology serve as the consultative body within the FMA in regard to the establishment of the location and organization of the School of Optometry and keep the FMA apprised of its recommendations in this area.

The Fifth Pathway—The Council reviewed information regarding the use of the Fifth Pathway by medical students who attend a medical school outside the United States and who wish to qualify to take the examination for medical licensure in the United States. The Council expressed full support for the position of the Board of Governors opposing the Fifth Pathway pending a report from the Committee on Medical Education.

CPT, CMIT—A presentation was made to the Council on the AMA's development of a codification system of medical, surgical, radiologic and laboratory procedures, (CPT) Current Procedural Terminology; codification of diagnoses, (CMIT) Current Medical Information and Terminology, and the AMA's pilot program feasibility studies in the area of PSRO and data collection. The disadvantages of present reporting methods and the advantages of electronic data processing and clarification of terminology were reviewed.

The Council expressed its endorsement of a pilot program in the area of PMUR and data collection and recommended that each of the specialty groups cooperate in the program. The Council also recommended that the FMA appoint a committee to work in this area.

FMA Relative Value Studies—The Council is pleased to have had input during the year in the work of the Committee on Relative Value Studies in updating the Florida Relative Value Study. The Chairman of the Council serves as a member on the Relative Value Studies Committee and has kept the Council informed of that committee's work. Specialty groups have participated in the development of a questionnaire to the FMA membership and have made recommendations regarding inclusion or omission of items in the survey.

Continuing Medical Education—One of the Council's functions is to assist the Council on Scientific Activities in its development and on-going review of CME requirements. The Council has been kept fully informed of the activities of the Committee on Continuing Medical Education. Individual specialty groups have participated in the development of criteria for the continuing medical education requirements for their individual specialty.

Report of Board of Governors

Scientific Exhibitors

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled "Scientific Exhibitors" was adopted. (See Report of Board of Governors, Page 56.)

FMA Journal

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled "FMA Journal" was adopted. (See Report of Board of Governors, Page 61.)

Collective Bargaining

The Reference Committee recommended that Recommendation No. 12 of the Report of Board of Governors be adopted.

Recommendation No. 12 of the Report of Board of Governors was adopted. (See Report of Board of Governors, Page 61.)

School of Optometry

Upon recommendation of the Reference Committee Recommendation No. 13 of the Report of Board of Governors was adopted. (See Report of Board of Governors, Page 61.)

Council on Specialty Medicine

The Reference Committee recommended that Recommendation No. 14 of the Report of Board of Governors be referred back to the Board of Governors for further study by the Council on Specialty Medicine.

Recommendation No. 14 of the Report of Board of Governors was referred back to the Board of Governors for further study by the Council on Specialty Medicine. (See Report of Board of Governors, Page 61.)

Criminal Acts and Psychiatry

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled "Criminal Acts and Psychiatry" was adopted. (See Report of Board of Governors, Page 61.)

Medical Service Projects

Upon recommendation of the Reference Committee Recommendation No. 15 of the Board of Governors Report was amended by replacing the word 'physician' in section 2 with the words, "Medical Doctor," and adopted as amended. (See Report of Board of Governors, Page 61.)

School of Optometry

The Reference Committee recommended that the words "and Committee on Medical Education" be added after the word "Ophthalmology" in the section of the Board of Governors Report entitled "School of Optometry."

The section of the Board of Governors Report entitled "School of Optometry" was amended by adding after the word "Ophthalmology" the words "and Committee on Medical Education."

Upon recommendation of the Reference Committee the section of the Board of Governors Report entitled "School of Optometry" was approved as amended. (See Report of Board of Governors, Page 62).

Recognition of Specialty Groups

Upon recommendation of the Reference Committee the item in the Board of Governors Report entitled "Recognition of Specialty Groups" was adopted. (See Report of Board of Governors, Page 62.)

Resolution 75-15
Inhalation Therapy
Pinellas County Medical Society

The Reference Committee recommended that Resolution 75-15 be referred to the Board of Governors for consideration by the Committee on Allied Health Professions.

Resolution 75-15 was referred to the Board of Governors.

Resolution 75-15

Inhalation Therapy

[Not Adopted—Referred to Board of Governors]

Whereas, There is insufficient regulation of the Inhalation Therapy industry and,

Whereas, Outpatient Inhalation Therapy Services have been marketed by unscrupulous and at times unqualified persons with at best marginal medical supervision, and

Whereas, There appears to be a need for legislation related to licensure, advertising, certification or registration, especially in regard to home use programs, therefore be it

RESOLVED, That the Inhalation Therapy Society be contacted; communicate our concern and assist in drafting appropriate legislation to correct those problem areas identified.

Resolution 75-32
Continuing Medical Education Accreditation Procedures
Hillsborough County Medical Society

The House was advised that this Resolution was not acted upon as no representative appeared before the Reference Committee to sponsor it.

Resolution 75-35
Fifth Pathway for Licensure

The House was advised that this Resolution was not acted upon as no representative appeared before the Reference Committee to sponsor it.

A motion was made and seconded from the floor of the House to bring Resolution 75-35 before this House to be considered as an emergency resolution.

The motion failed.

Dr. Yonge: "Your Chairman wishes to thank the members of this Committee, Doctors Jack W. MacDonald, John W. Glotfelty, Dick L. Van Eldik, and John Turner for their able and active participation in this group. I also wish to thank our secretary, Ms. Marcia Protheroe, for her fine assistance given the Committee.

"Mr. Speaker, I move the adoption of the report of Reference Committee No. I as a whole."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. I.

Report of Reference Committee No. II

Public Policy

The Vice Speaker, Dr. Kahn, assumed the Chair and called for the report of Reference Committee No. II.

Dr. Joseph H. Davis, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Council on Medical Services

Upon recommendation of the Reference Committee the words, "are summarized" in the first sentence of the second paragraph were changed to "is presented."

Committee on Drug Abuse

Upon recommendation of the Reference Committee the footnote concerning the paragraph on The Committee on Drug Abuse was deleted.

Upon recommendation of the Reference Committee the second paragraph of the Committee on Drug Abuse was deleted from the report, as testimony presented revealed that the problem of providing accurate urine screening analysis for residential treatment centers no longer exists.

The report of the Council on Medical Services was adopted as amended.

Council on Medical Services

ROBERT E. WINDOM, *Chairman*

The Council on Medical Services held two meetings during the past Association year 1974-75; these being on July 12, 1974, in Tampa and January 24, 1975, in Orlando. This Association year saw a reduction in the number of committees under the Council due to reorganization, by the FMA, of councils and committees. The previous program responsibilities of the eliminated committees were shifted to other committees.

A brief summary of each committee's activities for the year is presented in this consolidated Council report. Please note that several recommendations of the Council and its Committees were previously submitted to, and acted upon, by the Executive Committee and the Board of Governors and appear in the report of the latter body.

The Committee on School Health was one of the most active committees this year as it assumed the responsibilities of the previous Committees on Child Health and College Health. The Committee on School Health continued its role as the primary member of the School Health Medical Advisory Committee to the Department of Education and Division of Health, Department of Health and Rehabilitative Services. Serving in this capacity, the Committee continued to play an important role in encouraging the implementation of the Comprehensive Health Services Act, the School Health Act of 1974 and the Screening Centers Act of 1974.

A subcommittee, of the Committee on School Health, on nutrition under the Chairmanship of Dr. Donald I. MacDonald was established. This subcommittee is made up of representatives from many health related professions concerned with the problem of nutrition. Some of the topics considered this year have been 1) synthetic food additives 2) nutrition in the schools 3) the develop-

Reference Committee II considered Public Policy. Left to right: Andre S. Capi, M.D., Pompano Beach; Edward W. Stoner, M.D., Oviedo; Francis C. Coleman, M.D., Tampa; Philip B. Phillips, M.D., Pensacola; Recorder Cynthia Jones; and Joseph H. Davis, M.D., Miami, Chairman.

ment of a "nutrition quiz" to be aired over national television 4) the development of an article for publication in the FMA *Journal* regarding nutrition.

The Committee is proud to report, that with the support of the FMA Woman's Auxiliary, the Cancer Screening Program was successful in teaching 33,000 9th - 12th graders and 2,000 teachers how to do self-breast examinations.

Other areas of concern monitored by the Committee this year were 1) early school entry 2) child day care facilities licensure 3) confidentiality of school health records 4) immunization standards 5) physical examination forms for athletes 6) aerobics pilot program for Florida 7) safety education in schools 8) medications in the schools 9) sports medicine 10) the reduction and training requirements for various health related positions by the State of Florida.

The Committee on Public Health provided input into the FMA's proposed Legislation for establishing a separate department of health.

The Committee on Emergency Medical Services continues to be concerned over the need of physicians to receive cardiopulmonary resuscitation training and has requested the county medical societies help in promoting CPR training. The Committee reviewed the report of the State of Florida, Division of Communications, report on "911 in Florida" and reported their suggestion that personnel associated with the receiving and dispatching of EMS calls should have EMT training such as the standardized dispatching course which is currently available. In other actions, the Committee reviewed the need for categorization of emergency facilities in terms of various levels of emergency care. By the use of categorization of emergency facilities, the Committee feels that an organized system of referral and transfer of emergency patients will occur. The Committee plans to review the matter further.

The Committee on Tele-Communications has devoted its efforts toward pursuing the development of emergency medical services regional tele-communications plans and subsequent operations. The Committee is pleased to report that the Board of Governors has established an ad hoc committee to develop funding techniques that will insure the development of an effective voice in the matter of tele-communications without jeopardy to the resources of the FMA or its component medical societies. The Committee continues to recommend that each county medical society establish a committee on tele-communications through which cooperation and coordination with the FMA, other county medical societies and other agencies can be established in matters relating to the highly technical field of tele-communications.

A close relationship with the State of Florida, Division of Communications was maintained during this Association year resulting in a clearer understanding on the part of the Division as to the needs of medicine in the field of communications. The Committee is pleased to report that several hospitals are showing an interest in (medical) telecommunications and the importance of cooperating and coordinating their efforts with the FMA.

The Committee on Drug Abuse continues its concern over the devastating effect FMA reorganization has had on the ability of this committee to function in the best interest of the Association. The Committee has continued its efforts to develop a contract with the State of Florida Bureau of Drug Abuse and the Florida Medical Foundation for the purpose of reviewing and evaluating selected residential drug abuse treatment centers as to the availability of diagnostic, therapeutic, and emergency medical services. Once the contract is completed $50,000 will be placed in the Florida Medical Foundation for implementation of the contract.

The Committee on Rural Health continued to represent the FMA on the Florida Committee on Rural Health. However, the Committee is of the opinion that in the future the FMA Committee on Rural Health will also maintain a separate entity role and focus more attention on the needs of rural physicians. In order to speak to the needs of the rural physicians, the Committee has proposed that in the future, consideration be given to appointing members of the Committee to include 1) a representative recently engaged in rural practice 2) a representative with many years of experience in rural practice 3) a representative of the Family Practice Program from the medical schools in the state and 4) a liaison member from the FAFP Committee on Rural Health. The Committee is currently considering the suggestion that Florida medical schools develop three to six month rural preceptorships, with family physicians in truly rural areas of Florida, and scholarships for prospective students who are already married and whose wives' hopes and intentions are to return to a rural area.

Report of Board of Governors

Recommendation No. 1
Resolution 74-30
"Learning Disability" Program

Upon recommendation of the Reference Committee the words "-perceptual-motor" were added after the word "visual" in Recommendation No. 1.

The Reference Committee recommended that Recommendation No. 1 of the Report of Board of Governors be adopted as amended.

The Recommendation No. 1 was adopted as amended. (See Report of Board of Governors, Page 51.)

Upon recommendation of the Reference Committee Resolution 74-30, "Learning Disability" Program, was not adopted.

Councils and Committees

Upon recommendation of the Reference Committee, the title "Allied Professions and Vocations" was changed to "Allied Health Professions."

Recommendation No. 4
Allied Health Professions

Upon recommendation of the Reference Committee, Recommendation No. 4 of the Report of Board of Governors was adopted. (See Report of Board of Governors, Page 54.)

Recommendation No. 5

Upon recommendation of the Reference Committee, Recommendation No. 5 of the Report of Board of Governors was adopted. (See Report of Board of Governors, Page 54.)

Liaison with Allied Health Professions

Upon recommendation of the Reference Committee, the portion of the Report of Board of Governors entitled "Liaison with Allied Health Professions" was adopted. (See Report of Board of Governors, Page 54.)

Prescription Forms

Upon recommendation of the Reference Committee, the portion of the Report of Board of Governors entitled "Prescription Forms" was adopted. (See Report of Board of Governors, Page 54.)

Multi-Item Prescription Forms

The Reference Committee recommended that the portion of the Report of the Board of Governors entitled "Multi-Item Prescription Forms" be adopted as printed in the Handbook.

A motion was made from the floor not to adopt the recommendation of the Reference Committee.

The motion did not carry.

The portion of the Report of Board of Governors entitled "Multi-Item Prescription Forms" was adopted. (See Report of Board of Governors, Page 54.)

Committee on Voluntary Health Agencies

The Reference Committee recommended that the portion of the Report of Board of Governors entitled "Committee on Voluntary Health Agencies" be amended by deleting the second paragraph and renumbering items 1 and 2 under the second paragraph, making them items 13 and 14 under the first paragraph.

The recommendation to amend the portion of the Board of Governors Report entitled "Committee on Voluntary Health Agencies" was adopted.

As recommended by the Reference Committee the portion of the Board of Governors Report entitled, "Committee on Voluntary Health Agencies" was adopted as amended. (See Report of Board of Governors, Page 54.)

Council on Medical Services

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "State Drug Abuse Program" was adopted. (See Report of Board of Governors, Page 56.)

Committee on Tele-Communications

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "Committee on Tele-Communications" and Recommendation No. 10 was adopted. (See Report of Board of Governors, Page 56.)

CPR Training

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "CPR Training" was adopted. (See Report of Board of Governors, Page 56.)

Categorization of Emergency Facilities

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "Categorization of Emergency Facilities" was adopted. (See Report of Board of Governors, Page 56.)

Florida Committee on Rural Health

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "Florida Committee on Rural Health" was adopted. (See Report of Board of Governors, Page 56.)

Committee on Allied Health Professions

The Reference Committee recommended that the portion of the Report of Committee on Allied Health Professions entitled, "Joint Practice Committee on Medicine and Nursing" be amended by deleting the word "not" in the last sentence of the second paragraph.

The House was advised that in all probability the Florida Nurses Association will introduce recommended changes in the Nurse Practice Act during the 1975 Session. The recommendation was made from the floor to amend the recommendation of the Reference Committee by changing the last sentence of the second paragraph to read, "The Florida Nurses Association may not introduce recommended changes in the Nurse Practice Act during the 1975 Session."

The recommendation was amended and the portion of the Committee on Allied Health Professions Report entitled, "Joint Practice Committee on Medicine and Nursing" was adopted as amended, and referred to the Board of Governors for appropriate monitoring of this legislation by the Board and the appropriate committees, including the Committee on State Legislation, as recommended by the Reference Committee.

Upon recommendation of the Reference Committee, the Committee on Allied Health Professions was adopted as amended.

Committee on Allied Health Professions

LAUDIE E. MCHENRY, *Chairman*

The Committee held one meeting during the year on February 23, 1975. With the Council and Committee restructuring that resulted from the 1974 Annual Meeting, the Council on Allied Professions and Vocations was reduced from a Council with thirteen allied health committees to a four-man Committee on Allied Health Professions. Liaison with most of the allied health groups were maintained on an informal basis by members of the Committee and Association staff.

The Executive Committee requested the Committee to review and make recommendations as to the means of liaison with allied health professions as well as additional programs and projects with which it should involve itself. The Committee recommended to the Board a definition of allied health professions, criteria for formal recognition of allied health professions by the Florida Medical Association and establishment of liaison with recognized allied health professions.

The Committee received requests for recognition from several newly formed allied health groups but deferred action until the Board could act on its recommendations concerning recognition criteria.

The Committee and staff were responsible for communication with allied health professions to seek input and assistance in formulating and seeking passage of legislation that establishes a separate Department of Health Services. Several of the allied health professions have agreed to work with the Association to establish a separate Department of Health Services.

Active liaison and communication with the Florida Pharmaceutical Association was carried out by the Chairman. The Pharmaceutical Association identified several problems on which the Committee made recommendations to the Board of Governors. Problems identified by the Florida Pharmaceutical Association were the use of multi-item prescription blanks and the problem of identifying a physician signing a prescription when only his signature appears on a prescription. The Pharmaceutical Association has also introduced legislation to prohibit distribution of samples of medicinal drugs without a written request by someone authorized to prescribe or dispense such drugs. The Committee recommended endorsement of this legislation because it feels that if drug samples were supplied only upon request that it would provide better control, thus reducing the possibility of drug samples contributing to the drug abuse situation.

Joint Practice Committee on Medicine and Nursing —One member of the Committee, James J. DeVito, M.D., served as Co-Chairman of the Joint Practice Committee on Medicine and Nursing. The Joint Practice Committee held one meeting during this year, on January 19, 1975.

The Committee was asked by the Florida Nurses Association to review their proposed revision of the Nurse Practice Act. On January 19, 1975 the Committee reviewed the first two pages of Draft V and made recommendations to the Florida Nurses Association. The Committee will be asked to review the entire Act when the final draft is completed. The Florida Nurses Association may not introduce recommended changes in the Nurse Practice Act during the 1975 Session.

Committee on Voluntary Health Agencies

Upon recommendation of the Reference Committee the number of agencies as indicated in the last paragraph of the Committee on Voluntary Health Agencies Report was changed from 13 to 14.

Upon recommendation of the Reference Committee the last sentence of the Committee on Voluntary Health Agencies was deleted and the sentence, "The Florida Kidney Foundation did not reapply for renewal," was inserted in its place.

The report of the Committee on Voluntary Health Agencies was adopted as amended.

Committee on Voluntary Health Agencies

CHARLES P. HAYES, *Chairman*

The Committee on Voluntary Health Agencies is rounding out its first year as a one-man committee reporting directly to the Board of Governors.

The Committee met on November 16, 1974, with executive directors and physician advisors of most of the recognized voluntary health agencies. Also sitting in on the session were officers and staff of some of the allied professions with which FMA has formal liaison through the Committee on Allied Health Professions.

Purpose of this session was to explain FMA's concept of a separate Florida Department of Health Services and to solicit the support of the voluntary and allied organizations for such legislation. The Committee has kept in close touch with the voluntary agencies on this issue by letter and by telephone. Some of the agencies have endorsed our position, while others prefer not to take a stand.

Your Committee has recommended renewal of FMA recognition of 13 agencies for the coming year and provisional recognition of the Florida Coordinating Council of the National Kidney Foundation. The Florida Kidney Foundation did not reapply for renewal.

Resolution 75-20
Use of Florida Mental Hospital Facilities
Manatee County Medical Society

Upon recommendation of the Reference Committee Resolution 75-20 was referred to the Board of Governors for prompt study and appropriate action with the understanding that this is an urgent and critical issue and needs immediate attention.

Resolution 75-20

Use of Florida Mental Hospital Facilities

[NOT ADOPTED — REFERRED TO THE BOARD OF GOVERNORS FOR PROMPT STUDY AND APPROPRIATE ACTION WITH THE UNDERSTANDING THAT THIS IS AN URGENT AND CRITICAL ISSUE AND NEEDS IMMEDIATE ATTENTION.]

Whereas, The Manatee County Medical Society is a duly recognized affiliate organization of the Florida Medical Association; and

Whereas, The membership of the Manatee County Medical Society is dedicated to the furtherance of the quality of medical practice and the constitutional rights of patients in the mental hospitals of the State of Florida; and

Whereas, The recent directive from the State of Florida's Department of Health and Rehabilitative Services ordering that prisoners be housed at Florida's mental hospitals, and that Florida mental hospital facilities be confiscated for housing convicted felons is contrary to and in aggravation of basic philosophies of good medical practice, mental health, and is in violation of the natural and constitutional rights of patients; and

Whereas, The further perpetration of this authoritarian directive will unquestionably destroy therapeutic potentials and will cause undeniable harm to the mentally ill in our state hospitals;

Whereas, The Manatee County Medical Society unanimously opposes this directive to house criminals in the same facilities with the mentally ill; and now, therefore, be it

RESOLVED, That the Florida Medical Association reject in its entirety the directive to house sane criminals in the same facilities with the mentally ill and require its physician member organizations statewide to join in this resolution.

Dr. Davis: "Your Chairman wishes to thank the members of this Committee, Doctors Edward W. Stoner, Philip B. Phillips, Francis C. Coleman, and Andre S. Capi, the members who came to speak before the Committee, and our Secretary, Cindy Jones, without whose efforts, cooperation and assistance this report would not have been possible."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. II as a whole as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. II."

Dr. John C. Kruse of Jacksonville was recognized by the Chair for the purpose of conveying a point of information to the House. Dr. Kruse advised that the Florida Society of Anesthesiologists Board of Directors had requested that he convey to the House the fact that the slow down action of the Broward County Anesthesiologists was taken without prior knowledge or approval of the Florida Society of Anesthesiologists and further, the Florida Society of Anesthesiologists had adopted a resolution as policy for its members, resolving "that the Florida Society of Anesthesiologists encourage its members to practice as long as insurance is available at a reasonable cost, and be it further RESOLVED, that if such insurance is not available that the members of the Florida Society of Anesthesiologists be justified in restricting their scope of practice."

Everyone is all smiles as the new Board of Governors gathers for the first time. First row (left to right): House Speaker Louis C. Murray, M.D., Orlando; Vice President Irving M. Essrig, M.D., Tampa; Immediate Past President Thad Moseley, M.D., Jacksonville; President Vernon B. Astler, M.D., Boynton Beach; President-Elect Jack A. MaCris, M.D., St. Petersburg; Treasurer Richard S. Hodes, M.D., Tampa; and Secretary James W. Walker, M.D., Jacksonville. Second row: AMA Delegate Francis T. Holland, M.D., Tallahassee; Donald G. Nikolaus, M.D., Dunedin, District B; Theodore J. Marshall, Pensacola, District A; Thomas B. Thames, M.D., Orlando, District C; Eugene G. Peek Jr., M.D., Ocala, Dept. of Health and Rehabilitative Services; Richard C. Dever, M.D., Miami; Past President Joseph C. Von Thron, M.D., Cocoa Beach; Joseph G. Matthews, M.D., Orlando, Blue Shield; and Curtis W. Cannon, M.D., West Palm Beach, At Large. Benjamin M. Cole, M.D., Orlando, State Board of Medical Examiners was absent.

Report of Reference Committee No. III

Finance and Administration

The Speaker assumed the Chair and called for the report of Reference Committee No. III, Finance and Administration. Dr. John C. Fletcher, Chairman, and members of his committee came forward to present the report of his committee.

Report of Board of Governors
1974 House of Delegates Referral—
Resolution 74-22:
Representation on the FMA Board of Governors
Board Recommendation No. 2
Resolution 75-22
Task Force on Communications
Brevard County Medical Society
Resolution 75-26
Board of Governors
Broward County Medical Association
Resolution 75-31
Composition of Board of Governors
Hillsborough County Medical Association

The Reference Committee heard testimony on the resolutions and recommendations listed above and believes that limited elected enlargement of the Board of Governors is necessary to provide a more representative group. The Reference Committee recommended adoption of a substitute resolution to be called Substitute Resolution 75-22.

Substitute Resolution 75-22 was adopted.

Substitute Resolution 75-22

Task Force on Communications

RESOLVED, that this House of Delegates move immediately to implement the separation of the offices of Secretary and Treasurer to provide a wider geographic representation on the Board of Governors, and be it further

RESOLVED, that these candidates be nominated and elected by this House of Delegates, and be it further

RESOLVED, that the President and the Board of Governors of the Florida Medical Association initiate a Task Force on Communications in order to devise an efficient and rapid means of communication (two-way) between Florida Medical Association Headquarters and the President of each component county medical society, and the President of each specialty society of the FMA and that study by this task force should include full utilization of sophisticated methods to disseminate rapidly priority material which would demand local attention and action.

Upon recommendation of the Reference Committee Recommendation No. 2 of the Board of Governors report was adopted. (See page 51).

1974 House of Delegates Referrals
Resolution 74-33
Examination for Florida Licensure

Upon recommendation of the Reference Committee, Resolution 74-33 was not adopted.

Reference Committee III considered Finance and Administration. Left to right: John C. Fletcher, M.D., Tampa, Chairman; Recorder Carolyn Miller; Joseph P. Hendrix, M.D., Port St. Joe; Richard B. Moore, M.D., West Palm Beach; Joseph H. Fitzgerald, M.D., Miami; and Jack Q. Cleveland, M.D., Coral Gables.

Recommendation No. 6
Madison County Medical Society

The Reference Committee advised the House that Madison County Medical Society now has 5 dues paying, fully qualified members and recommended that Recommendation No. 6 not be adopted and that the Madison County Medical Society continue with its charter.

Recommendation No. 6 of the Board of Governors Report was not adopted.

Recommendation No. 16
By-Laws Amendments

Upon recommendation of the Reference Committee the first subtitle under Recommendation No. 16 of the Board of Governors Report was corrected to read, "Special Meetings of the Association."

The Reference Committee recommended that the portion of Recommendation No. 16 entitled, "Called Meetings of the House of Delegates" not be adopted because of the uncertainty of the postal system. The Reference Committee advised that the United States Postal Service does not now furnish a dated postmark.

The portion of Recommendation No. 16 entitled, "Called Meetings of the House of Delegates" was not adopted.

The Reference Committee recommended that an amendment to the FMA By-Laws, Chapter IV —House of Delegates, Section 14—Privilege of the Floor, be formulated which would extend the privilege of the floor to general officers of the AMA who are members of the FMA, and that this be referred to the Board of Governors with the request that such an amendment be presented to the House of Delegates in 1976.

The recommendation of the Reference Committee was adopted.

Upon recommendation of the Reference Committee the portion of Recommendation No. 16 entitled, "Privilege of the Floor at the House of Delegates" was adopted.

Upon recommendation of the Reference Committee the Report of the Board of Governors was adopted as amended with the exception of those portions of the report which were referred to the other Reference Committees.

Report of Board of Governors

THAD MOSELEY, *Chairman*

During the past Association year, 1974-75, your Board of Governors held 7 meetings. The Board held its regularly scheduled meetings on May 12, 1974, October 10-11, 1974, January 12, 1975 and March 8, 1975. In addition, there were 3 called meetings of the Board, two of which were telephone conference calls, on November 22, 1974, February 12, 1975 and February 22, 1975.

This has been a difficult year. Your officers and Board have spent long hours in their efforts to cope wisely and in the best interests of their colleagues with the crucial issues which organized medicine faces. Your Chairman is grateful to have had the privilege to serve with those who served on the Board this past year. They have exhibited sincere dedication to the integrity and principles of our profession. They have served the FMA and their fellow physicians well.

Your Chairman will remember always the honor of having served as President of this fine organization, and for this, is deeply grateful.

Major Actions

During the past year your Board of Governors and Executive Committee have spent over 70 hours in session. The following is a summary of the major activities and actions of the Board in its deliberations, and its recommendations to the House of Delegates.

1975 Annual Meeting—The Board approved the format for the 1975 Annual Meeting and was pleased to note that for the first time in many years the scientific program had been complete and presented at the January Board Meeting. Dr. Yank Coble, Vice Chairman of the Committee on Continuing Medical Education was commended for his contribution toward this effort.

FMA Leadership Conference—The Florida Medical Association's 17th Annual Leadership Conference for County Medical Society officers was held on Saturday, January 25, 1975 in Orlando. The conference attracted some 167 physicians and guests. Thirty-one county medical societies participated, representing over 95 percent of the FMA membership. The all-day conference was followed on Sunday morning by a panel on state and national legislation. Major emphasis was on the 1975 FMA legislative program priorities for professional liability insurance and establishment of a separate Department of Health Services.

Financial Statement and Budget—The Board reviewed the financial statement prepared by the Executive Vice President and approved the auditor's statement presented by the Secretary-Treasurer, prepared by Lucas, Herndon, Hyers, and Pennywitt, Certified Public Accountants. This audit report, which covered calendar year 1974, showed Association income from all sources was $836,151.94 and total expenses during the year were $835,678.44. This gave the Association an excess $473.50 in income over expenditures. These figures do not include funds expended for equipment and interest paid as these are carried under fixed assets of the Association. The net result was that the Association showed a deficit in its 1974 budget.

The Board approved a budget for 1975 totaling $1,273,000 which is anticipated income from all sources and includes the dues increase which became effective January 1, 1975. In compliance with the By-laws, the budget was prepared by the Executive Vice President in consultation with the Secretary-Treasurer. The budget was reviewed by the Executive Committee and approved by the Board of Governors.

Headquarters—At the approval of the Board of Governors an additional 4,200 square feet of office space have been added to the FMA headquarters building. The addition, which was completed in November, 1974 at a cost of $166,645 brings the total of office space to over 12,000 square feet.

The additional space has had positive affects on the efficiency of the office and will allow for the future expansion of activities of the Association.

Appointments—The Board of Governors approved the nomination of Francis T. Holland, M.D. as the AMA Delegate to serve on the Board of Governors. Richard C. Dever, M.D. was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Joseph G. Matthews, M.D., Blue Shield of Florida, Inc.; Vernon B. Astler, M.D., President-Elect serves as the Florida State Board of Medical Examiners representative on the Board; and Louis C. Murray, M.D., Speaker of the House of Delegates. William J. Dean, M.D. was designated as Public Relations Officer. Joseph C. Von Thron, M.D. was designated as the Board's representative to FLAMPAC.

In January, 1975, Gerold L. Schiebler, M.D. was appointed to serve as Editor of the *Journal of the Florida Medical Association* for 1975-76 replacing Clyde M. Collins, M.D. who has completed five years service as Editor of the *Journal*. William M. Straight, M.D. was appointed FMA Historian and Historical Editor of the *Journal* and Richard C. Dever, M.D. was designated as the Board of Governors representative on the Scientific Publication Committee.

Appointed as Chairmen of Committees of the Board were:

Committee on Allied Health Professions
Laudie E. McHenry Jr., M.D.
Committee on Voluntary Health Agencies
Charles P. Hayes, M.D.
Committee on County Medical Society Presidents
John H. Terry, M.D.
Appointed as Chairman of a *Special Committee of the Board on Member Participation* was John N. Carlson, M.D.

Francis T. Holland, M.D. and Burns A. Dobbins Jr., M.D. were reelected Chairman and Vice-Chairman respectively of the FMA Delegates to the American Medical Association.

Awards

The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the first meeting of the House of Delegates on April 23, 1975. The recipient for this year's award is included in the delegates' packets.

Layman's Award—The House of Delegates in 1972 established a Distinguished Layman's Award. The purpose of the award is to recognize individuals who have made significant and lasting contributions to the medical profession. The House directed the Board to develop the criteria for establishing the award and further that the Board would select the recipient.

The Board has selected Capt. John Waters of Jacksonville as the 1975 recipient of the Distinguished Layman's Award. The appropriate citation, along with criteria, is included in the delegates' packets for information.

Nominations

The Board is pleased to nominate to the House of Delegates three distinguished physicians to receive the Certificate of Merit (the Association's highest honor of achievement), and the Certificate of Appreciation. These nominations are included in the delegates' packets for presentation at the first meeting of the House of Delegates.

Judicial Council—In compliance with the FMA By-laws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1975, and to fill an unexpired term created by the death of Dr. Nelson Zivitz.

The Board nominates William W. Thompson, M.D. of Ft. Walton Beach to the House of Delegates for reelection to the Judicial Council for Medical District A for a five-year term following his current term which expires in 1975; and William M. Straight, M.D. for election to the Judicial Council for Medical District D to fill the unexpired term created by the untimely death of Nelson Zivitz, M.D.

Committee on Membership and Discipline—In compliance with the By-laws, the Board has reviewed terms expiring in 1975 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:

District 1—Philip B. Phillips, M.D. (79)
District 2—Robert P. Johnson, M.D. (79)
District 3—Hugh A. Carithers, M.D. (79)
District 4—Carroll M. Crouch, M.D. (79)
District 5—Frank C. Bone, M.D. (79)
District 6—John P. Ferrell, M.D. (79)
District 7—Linus W. Hewit, M.D. (79)
District 8—Roger A. Meyer, M.D. (79)
District 9—Hector R. Mendez, M.D. (79)
District 10—Gordon H. McSwain, M.D. (79)
District 11—Myrl Spivey, M.D. (79)
District 12—Miles J. Bielek, M.D. (79)
District 13—John G. MacLure, M.D. (79)
District 14—Robert J. Schiess, M.D. (79)
District 15—Sol Colsky, M.D. (79)
Norman M. Kenyon, M.D. (76)

Blue Shield Board of Directors—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Medical District A—One Vacancy—Three Year Term
James L. Borland, M.D., Jacksonville
John Parker, M.D., Perry
Medical District B—One Vacancy—Three Year Term
David K. Davis, M.D., St. Petersburg
David A. Giordano, M.D., Sarasota
Medical District C—One Vacancy—Three Year Term
Andre S. Capi, M.D., Pompano Beach
G. Brock Magruder, M.D., Orlando
At Large—One Vacancy—Three Year Term
Raymond A. Fitzpatrick, M.D., Gainesville
Daniel Seckinger, M.D., Miami

Lay members nominated by the Nominating Committee and approved by the Board are:

Medical District A—One Vacancy—Three Year Term
Lee E. Willis, Tallahassee
Medical District B—One Vacancy—Three Year Term
John A. Turner, Lakeland
Hospital Admin./Blue Cross Board Member—One Vacancy—One Year Term
Robert T. Besserer, Sanford

Florida State Board of Medical Examiners—In compliance with the House of Delegates' policy, the Board of Governors, taking into consideration recommendations by component medical societies, compiled a list of physicians which was forwarded to Governor Reubin Askew for his consideration in making appointments to the Florida State Board of Medical Examiners.

AMA Councils and Committees—The Board was pleased to submit the nominations of the following physicians for reappointment to AMA councils and committees.

Samuel M. Day, M.D., Committee on Insurance
O. Frank Agee, M.D., Committee on Quackery
James W. Walker, M.D., Committee on Nursing
Yank D. Coble Jr., M.D., Council on Foods and Nutrition
Roy M. Baker, M.D., Committee on Community Emergency Services

Referrals by House of Delegates

The 1974 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

Resolution No. 74-5, AMA Council on Medical Education—This resolution was adopted by the House of Delegates and referred to the Board of Governors for introduction at the appropriate time. The resolve of this resolution recommends that Chapter XI, Section 2 (B) of the By-laws of the American Medical Association be altered to read as follows: "The Council on Medical Education shall consist of ten Active Members, of which, not less than one nor more than five shall be a member of a medical school full-time faculty. Members of the Council shall be elected by the House of Delegates for terms of five years, so arranged that each annual convention the terms of two members shall expire."

Introduction of this resolution in the AMA House of Delegates was deferred so as not to jeopardize the election of Richard G. Connar, M.D. a private practitioner, to the AMA Council on Medical Education and who was being sponsored by the Florida Medical Association. Several other similar resolutions were introduced and the Reference Committee on Constitution and By-laws prepared a substitute resolution which was adopted by the House.

> "Resolved, that the current status of all members of the Council on Medical Education, with reference to the faculty appointments, salaried positions in education and percentage of time devoted to private practice, be included in the report of the Board of Trustees nominating members of the Council."

Resolution 74-30, "Learning Disability" Program—This resolution was not adopted but referred to the Board for study by the appropriate committee. The resolve of this resolution provides that physicians in the state endorse a program for LD children whereby parents may be reimbursed for special education for these children not provided in the public school system. This resolution was reviewed by the Council on Specialty Medicine and the Council on Medical Services.

RECOMMENDATION NO. 1

The Board of Governors recommends to the House of Delegates that the Florida Medical Association oppose the expenditure of any public funds for reimbursement of money spent for visual-perceptual-motor training in relation to learning disabilities, as being scientifically and medically unsound, as documented in a joint statement of the American Academy of Pediatrics, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology. (Amended R.C. II)

Resolution 74-22, Representation on the FMA Board of Governors—This resolution was not adopted but referred to the Board for indepth study. The resolves of this resolution called for enlarging the Board of Governors and the Executive Committee so as to be more representative of the membership in the entire state.

This resolution was referred to the Special Committee on Member Participation and was subsequently presented as a part of that committee's program at the 1975 FMA Leadership Conference. At its March meeting, the Board reviewed the report and recommendations of the committee regarding this resolution and discussed at length the pros and cons of expanding the size of the Board and Executive Committee.

RECOMMENDATION NO. 2

The Board of Governors recommends to the House of Delegates that the current composition of the Board not be changed and that Resolution 74-22, "Representatives on the FMA Board of Governors" be disapproved.

Resolution 74-33, Examination for Florida Licensure—This resolution was not adopted but referred to the Board of Governors for study. The resolve of this resolution provides that the FMA petition the Board of Medical Examiners to delete certain questions from the application for examination relating to mental health and psychotherapy.

The State Board of Medical Examiners has met with a group of psychiatrists and heard their concerns, but the Board felt that these questions of concern could not be deleted as it very possibly would result in bringing sick doctors to the State. The Board emphasized that in no way are the answers used to jeopardize the initial examinations. It was noted that a psychiatrist is now on the Board of Medical Examiners, which should alleviate the problem somewhat.

Board Actions of Major Importance

1. Florida Physicians Association—The House of Delegates in 1972 adopted in principle Resolution No. 71-4 and directed that the FMA organize and sponsor a corporation dedicated to the private practice of medicine. The Florida Physicians Association, Inc. is directly responsible to the FMA. Through a contract, the FMA provides administrative services to the FPA in the same manner as the Association's agreement with recognized specialty groups.

The Board has approved the listing of the FPA in the "Florida Organizations of Medical Interest, Meetings and Officers" that appears in the FMA *Journal*.

Under the provisions of the Articles of Incorporation of the Florida Physicians Association, Inc., nominations to the FPA Board of Directors were submitted and approved by the FMA Board of Governors. A summary of the activities of the FPA is included in the Delegates' Handbook.

2. Council and Committee Structure—The 1974 House of Delegates adopted amendments to the FMA By-laws placing the responsibility for the composition and structure of FMA Councils and Committees with the Board of Governors, exceptions being the Judicial Council, Membership and Discipline Committee, and the Council on Specialty Medicine.

Pursuant to the instructions of the House, the Board has approved the composition, structure, and procedures of the Association's councils and committees, and guidelines under which they will function.

3. FMIT Program-Psychiatric Benefits—Resolution 74-34 adopted by the 1974 House of Delegates resolved that the Florida Medical Insurance Trust Committee meet with the Council on Florida District Branches of the American Psychiatric Association (representing psychiatry in Florida) without delay for the purpose of restoring major medical coverage of nervous and mental disorders in the Florida Medical Insurance Trust.

As a result of an indepth review of the program experience, the Board authorized a survey of the members covered under this program to determine if a majority of the members would like to have this benefit again included in the FMIT program.

The following benefits will again be included, should the membership elect to have them restored.

In-hospital admissions will be covered the same as other illnesses under the Major Medical part of the coverage.

Out-of-hospital doctor services for mental or nervous conditions will pay 50 percent of Reasonable & Customary fees charged. (Filed-R.C. V)

4. PSRO—Following the instructions of the 1974 House of Delegates regarding PSRO the Board voted to convey to the Congress and the AMA the priorities adopted by the House and designated Joseph C. Von Thron, M.D. to coordinate this activity. Some months following, in October, 1974 the Board was asked to call a special meeting of the House of Delegates to reconsider the actions of the House regarding PSRO. The Board chose not to do so as the petition for a called meeting was not made in compliance with the By-laws which require a petition of three county medical societies. Subsequently, upon receipt of requests from Dade, Duval and Hillsborough county medical societies, the President issued the call for a special meeting of the House to reconsider the previous actions of the House regarding PSRO. The Board has since continued to follow the policy adopted by the House of Delegates in May, 1974 and reaffirmed at its special called meeting in December, 1974. (Filed-R.C. V)

5. Director, Division of Health—The Board expressed congratulations to E. Charlton Prather, M.D. of Clay County who was appointed Director of the Florida State Division of Health. Dr. Prather replaces Wilson T. Sowder, M.D. who retired after serving as State Health Officer for some 40 years.

6. PMUR—The Board approved the agreement between Blue Shield of Florida, Inc. and Florida Medical Foundation for the purpose of continuing peer review in the State of Florida for Medicare commencing July 1, 1974 for a period of one year.

But in doing so, the Board directed that a covering letter be sent to the Social Security Administration advising that the physician's fee is $50 per hour for peer review, however, as it is the wish of the Florida Medical Association and Florida Medical Foundation to continue a working relationship at this time, the agreement at the rate of $35 per hour for time spent in review and $35 per hour for time spent in preparation of review is acceptable. (Filed-R.C. V)

7. Honorary Membership—The Board of Governors granted honorary membership status in the FMA to: Wilson T. Sowder, M.D. Jacksonville and Howard E. Hill, M.D., AMA Delegate from the Virgin Islands.

8. AMA Delegates—The Board was pleased to note that as of December 31, 1974 the FMA had 6,480 members who were members of the AMA thus giving Florida a 7th delegate. The AMA has been notified that the additional delegate will be elected at the forthcoming FMA Annual Meeting, April 23-27, 1975.

9. AMA Board of Trustees—The Board of Governors enthusiastically expressed its support for the reelection of Jere W. Annis, M.D. to the AMA Board of Trustees when his term expires in July, 1975. The FMA delegation to the AMA indicated that they would do everything possible to gain Dr. Annis' reelection. It was noted that Dr. Annis had been a great asset to the Board and that now more than ever his influence was needed.

10. Integrated Bar of Medicine—The Board reiterated previously established policy that the Florida Medical Association not support the concept of an "Integrated Bar of Medicine" at this time. Alternative proposals are included in the Judicial Council report to the House of Delegates.

11. Woman's Auxiliary—One of the greatest assets of the Association is the Woman's Auxiliary. Not only does the Auxiliary carry on many successful fund raising projects for the Florida Medical Foundation, but also has been engaged in innumerable worthwhile medical service projects at the local and state level. The Board approved Auxiliary's program for 1974-75 and the theme, "Get Involved." The Auxiliary's goal is to become more involved in legislative activity through personal contact with legislators and increased support in the FLAMPAC area. The Auxiliary has stressed health education in schools and increased emphasis on public relations work.

The Board is grateful to the Auxiliary for their unselfish and untiring efforts in enhancing the understanding between the public and the medical profession and for doing their part in assisting the FMA in carrying out its ultimate goal, the betterment of health care for the citizens of Florida.

12. Medical Advisory Committee to Department of Highway Safety and Motor Vehicles—The Board extended special commendation to Francis T. Holland, M.D. for over 20 years of voluntary work on the Medical Advisory Committee to the Department of Highway Safety and Motor Vehicles, noting that his service has contributed vastly to placing Florida in the forefront in this area.

13. Judicial Council—The Board approved the interim appointment of William M. Straight, M.D. of Miami to the Judicial Council for Medical District D to fill the vacancy created by the death of Nelson Zivitz, M.D.

14. FMA Medical Districts—The Board reviewed the membership in the state's four medical districts and the increases and decreases in membership were noted. The Board did not feel that it was necessary to consider redistricting at this time.

Membership

District	January, 1974	January, 1975	Change
A (North)	1,643	1,798	+155
B (West)	2,262	2,432	+170
C (East)	2,598	2,805	+207
D (South)	2,578	2,832	+254

15. Quality of Life Conference—The Board approved co-sponsorship with the National Foundation and the Junior League, the National Foundation's "Quality of Life Conference" with no financial obligation to the Association.

16. FMA Insurance Programs—The Board took the following action with regard to the FMA sponsored insurance program.

1. Approved an increase in the insurance coverage available under the office overhead policy from $2,000.00 a month benefit to $3,500.00 per month to include guaranteed coverage for persons under age 40 with benefits of $500.00 per month.
2. Approved a rewrite of the Castastrophic Hospital Program to include the coordination of benefits provision in all hospital policies.
3. Approved an Association sponsored Workmen's Compensation Program. (Filed-R.C. V)

17. Medicaid Program-Length of Stay Criteria—The Board reviewed a Medicaid "Provider" Letter which was mailed out by the Director of the Division of Family Services, Department of HRS concerning the institution of a hospital length of stay recertification program for the Medicaid Program. The directive indicated that this action was taken because of an anticipated financial deficit of approximately $5 million by the end of this fiscal year, due to increased utilization of inpatient hospital services by Medicaid recipients. The letter also stated that FMA representatives served on a committee which developed a manual listing the schedule of allowable days per type of diagnosis.

The Board instructed that the Division of Family Services be asked to retract the statement regarding FMA participation as FMA representatives had not participated, neither in preparation of the letter nor in promulgation of this directive.

The Board was of the opinion that this deviated from the standards set up in the Federal Register and felt this action was grounds for an injunction.

The Board has deferred any legal action in Florida pending outcome of the suit filed by AMA on behalf of the Federation to block the regulations. (Filed-R.C. V)

18. Congressional Visit 1975—The question was raised as to whether or not the FMA should continue its annual Congressional Visitation. It was suggested that the entire delegation not go up on one particular day, but that individuals be sent to confer with the legislative leaders at different intervals as needed. It was felt that this would be much more effective.

The Board agreed not to sponsor a yearly Congressional Visit, but to send individual key contacts to Washington as deemed necessary to accomplish an individual purpose.

19. Professional Liability Insurance—The Board of Governors has been advised by the attorneys for Teledyne and the Argonaut Insurance Company of their intentions to increase the premiums for the 5,500 physicians insured under the FMA program by approximately 94.8 percent, effective April 1, 1975, and to terminate all policies, December 31, 1975. This is in addition to a 96 percent increase which became effective January 1, 1975.

Both of the actions are in direct violation of a legal contract which the Argonaut Insurance Company entered into with the FMA which does not terminate until December 31, 1977. (Filed-R.C. V)

The Board of Governors reviewed this subject on March 8, 1975 and by unanimous vote, reaffirmed its decision that upon breach of contract by the Argonaut, the FMA would enter suit in the appropriate court and pursue this breach of contract as vigorously as possible.

It further reaffirmed that in the event that coverage is not available from conventional sources that the FMA will organize a medical liability mechanism. This mechanism can only be activated with adequate participation by physicians and only upon implementation of specifically stated statutory relief.

The Board further reaffirmed to specifically request the Florida Legislature to enact legislation at the earliest possible date to:

1. Place a limit on the amount of liability that could be awarded an individual on account of tort or negligence.
2. A. Place an absolute limit on the statute of limitations of two years.
   B. Define informed consent.
   C. Providing no guarantee of results of treatment may be valid and enforceable unless in writing.
   D. Define Res Ipse Loquitur.
3. Provide that the courts establish mandatory arbitration panels requiring a preponderance of evidence for tort or breach of contract or negligence. Arbitration panel evidence would be admissible in court in the event of trial.

The Board expressed continued support of previously adopted legislative objectives regarding placing a limitation on contingency fee arrangement in negligence cases and prohibiting the Ad Danmum Clause.

20. Blue Shield—The Board of Governors took the following actions with regard to Blue Shield.

Medicare Part B Program—Recommended to the Blue Shield Board of Directors that they continue as fiscal intermediaries for the Medicare Part B Program for the State of Florida, less Dade and Monroe Counties, for the new contract year, 1975-76.

Limitation of Liability—Formally protested the federal regulations as set forth under Section 213, Public Law 92-603, Medicare Part B Limitation of Liability Provision.

Assignments—Instructed that the membership be advised through a copy of the "Briefs," the risks involved in accepting assignments under the new federal regulations for Medicare Part B.

Completion of Insurance Forms—Agreed also to include in an issue of the "Briefs" the actions of both the AMA and the FMA pertaining to the completion of insurance forms, and to request physicians to provide complete and adequate information on the forms when filling them out.

Chiropractic—The Board reviewed legislation which requires insurers, as of October 1, 1974, to offer upon request benefits for chiropractic services, and took note of the necessity for Blue Shield to obtain the services of a chiropractic consultant for the processing of chiropractic claims when necessary, as required by the law. It was the feeling of Blue Shield that as Medicare "B" carrier for Florida, they are obliged to adhere to its contractual obligations.

The Board received this report as information but indicated to Blue Shield that the Board of Governors finds the entire chiropractic situation as it pertains to the Medicare "B" Program repugnant.

RECOMMENDATION NO. 3

The Board of Governors recommends to the House of Delegates adoption of the following resolution regarding use of FMA coding for claims.

Whereas, in December, 1974, after considerable delay, the Social Security Administration approved the use of the five digit Florida Medical Association coding for claims billing and processing purposes under Part B of the Medicare program, and

Whereas, It is recognized that use of the five digit code will decrease, significantly, mispayments, misinterpretations, unnecessary questions, and payment delays in the processing of claims by third party payors in public and private programs, now therefore, be it

RESOLVED, That all members of this Association be urged to adopt and implement in their office procedure the use of the FMA five digit coding or Blue Shield supplemental interim coding which has as its reference base the FMA five digit codes. It is urged that this system be used on all third party claim forms or bills issued to patients. Universal acceptance of this procedure is desirable in order that an acceptable reporting structure can be made the official policy position of the FMA relative to all third party carriers.

21. Special Committee on Member Participation—The Board of Governors approved the President's recommendation to appoint a special committee to study and make recommendations as to methods for improving broader participation of the membership in the activities of the FMA. The committee participated in the 1975 Leadershp Conference and has subsequently developed a number of helpful recommendations several of which are included in the actions and recommendations of the Board of Governors.

22. Past Presidents—The Board of Governors reflected with sadness at the news that two FMA Past Presidents had passed away. Dr. Joseph S. Stewart of Miami who served as President in 1948 died on November 28, 1974 and Dr. Robert E. Zellner of Orlando who served as FMA President in 1962 died on February 23, 1975. Both these fine physicians were held in high esteem by their colleagues and will be sorely missed.

FMA Councils and Committees

The Delegates' Handbook will reflect the many hours of work that have gone into the activities of the Association's councils and their committees. Many physicians have given freely of their time in the programs of the Association, and your Board is grateful for their dedication and interest in improving the quality and quantity of health care for the citizens of Florida. The following is a summary of the Board's actions regarding the recommendations of the councils. A complete summary report on the activities of all the Association's councils and committees is included in the Delegates' Handbook.

ALLIED HEALTH PROFESSIONS

RECOMMENDATION NO. 4

The Board of Governors recommends to the House of Delegates adoption of the following definition of an Allied Health Profession:

"An Allied Health Profession is any formally organized group whose members are involved in and/or educated in a technical or paraprofessional field relating to the delivery of medical care. The organization must be one in which there is input by the medical profession either in an advisory and/or academic capacity."

RECOMMENDATION NO. 5

The Board of Governors recommends to the House of Delegates adoption of the following criteria for recognition of Allied Health Professions.

1. That a group requesting recognition be organized on a statewide level, or have the potential to do so.
2. That it be endorsed by the Florida Medical Association component group with which it most closely associates (when one exists).
3. That its purpose and need are not covered nor in conflict with an already existing organization.
4. That its structure will assist and not deter other related groups.
5. That a preliminary constitution and/or by-laws state its organizational structure purposes and aims.

Liaison with Allied Health Professions—The Board of Governors approved an outline for maintaining liaison with Allied Health Professions.

Prescription Forms—The Board agreed that each prescription form written by physicians should clearly identify the physician prescribing the medication whether it be typed, printed or affixed by use of a rubber stamp; that a prescription form shall also contain contact information so that the pharmacist can readily communicate with the M.D. if needed; and further that pharmacists not honor a prescription unless the physician is clearly identified and/or known by the pharmacist.

Multi-Item Prescription Forms—The Board approved the recommendation that the use of multi-item prescription forms be generally condemned; that if it becomes necessary to utilize multi-item prescription forms that only like categories of drugs be entered on a given prescription since it is especially important that separate prescriptions be written for Schedule II drugs (narcotics, opiates, etc.), and that pharmacists not honor prescriptions for controlled drugs unless prescribed as above.

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

The Board approved official FMA renewal of recognition for 1975-76 for the following voluntary health agencies which have met the criteria established by the Association:

1. Arthritis Foundation, Florida Chapter
2. American Cancer Society, Florida Division
3. Florida Heart Association
4. Leukemia Society of America, Florida Division
5. Florida Lung Association
6. Mental Health Association of Florida, Inc.
7. National Multiple Sclerosis Society, Southeast Region
8. United Cerebral Palsy of Florida, Inc.
9. National Foundation—March of Dimes
10. Florida Epilepsy Foundation, Inc.
11. Easter Seal Society for Crippled Children & Adults of Florida, Inc.
12. Florida Association for Retarded Children
13. The Florida Society for the Prevention of Blindness, Inc.
14. Muscular Dystrophy Associations of America, Inc., Florida District

The Board granted provisional approval of the National Kidney Foundation for one year. (Amended—R.C. II)

JUDICIAL COUNCIL

Madison County Medical Society—The Board of Governors was advised that the membership of the Madison County Medical Society early in 1974 had been reduced to four, one less than the minimum necessary to retain its charter under the By-laws of the Florida Medical Association. The Judicial Council has reviewed the status of the Madison County Medical Society.

RECOMMENDATION NO. 6
(Not Adopted—R.C. III)

Medical Practice Act—The Board considered the need for the FMA to undertake a comprehensive study of the Medical Practice Act of Florida and all other laws relating to the practice of medicine, the capabilities and resources of the Board of Medical Examiners to enforce these laws; and a review and determination of the adequacy of the definition of the practice of medicine. The main objective of such a study is to bring these items up-to-date and to put into the Medical Practice Act that the Board of Medical Examiners may deputize any licensed physician to aid the Board when it is deemed necessary.

The Board approved the appointment of a committee to work with the State Board of Medical Examiners for the purpose of undertaking such a study.

COUNCIL ON LEGISLATION AND REGULATIONS

PSRO Legislative Action—The Board requested Joseph C. Von Thron, M.D., as a Past President of the FMA, member of the Board of Governors, and member of AMPAC, to provide guidance to the Council on Legislation and Regulations as to what legislative action, if any, the Council should take with regard to Professional Standard Review Organizations.

Legislative Coordination—The Board approved in principle the policy statement on coordination of legislative programs and activities developed by the Council on Specialty Medicine, and the guidelines developed by the Chairman of the Council on Legislation and Regulations and Chairman of the Council on Specialty Medicine, to implement this policy statement.

Trial Lawyers Conference—The Board agreed to distribute to county medical societies for their information, the general principles covered at a recent trial lawyers conference held for the purpose of educating attorneys on how to sue physicians.

National Health Insurance—The Board approved the principles adopted by the AMA Board of Trustees as guidance to the FMA in working for an acceptable national health insurance bill, ad authorized the Committee on National Legislation to educate county medical societies about them.

Action on Proposed Legislation

SBME-Laymen—Approved the position of the FMA on legislation to place a layman on the SBME as "Disapprove."

Department of Professional and Occupational Regulations—Approved the position of the FMA on legislation to abolish the Department of Professional and Occupational Regulations as "Endorse."

Administrative Procedures Act—Approved the position of the FMA on legislation to amend the Administrative Procedures Act to allow physicians to conduct disciplinary hearings as "Support."

Rate Review Committee for Hospital and Nursing Homes—Approved the position of the FMA on legislation to establish a rate review commission for hospitals and nursing homes as one of "Oppose."

School of Osteopathy—Approved the position of the FMA on legislation to establish a School of Osteopathy as one of "Oppose."

Legislative Priorities—The Board approved the priorities for legislation being sponsored by the Association in 1975 as follows:

1. Professional Liability Insurance Package—The Board of Governors of the FMA has approved a legislative program for medical malpractice for early adoption by the Florida Legislature which has been outlined in this report.
2. Separate Department of Health Services—Pursuant to the previously established policy of the House of Delegates, the Board of Governors approved FMA sponsorship of legislation in the 1975 session of the Legislature to create a separate Department of Health Services and that this program be begun as soon as possible in cooperation with all interested groups.

   While continuing to place primary emphasis on creation of a separate Department of Health, the Board agreed to consider alternative approaches that might satisfactorily carry out the objectives of the Association in the event the Department of Health Services legislation does not appear likely to pass.

Capital Office—The Board approved allocation of additional funds in the FMA budget for needed improvements in the Capital Office.

National Legislation—Because of the ever-increasing activities at the national level on such issues as health planning and national health insurance, the Board has authorized the Committee on National Legislation to begin regular quarterly meetings and to send (on a quarterly basis) a summary of key national legislative issues and suggested activities for Florida physicians to take on these matters, to key physicians in Florida.

RECOMMENDATION NO. 7

The Board of Governors recommends to the House of Delegates that the Association take whatever action necessary to work with the AMA in defeating SB 482 (Kennedy approach to medical malpractice situation and any like legislation).

RECOMMENDATION NO. 8

The Board of Governors recommends to the House of Delegates that FMA continue to maintain the position of opposition to a health care commission in Florida which would regulate hospital and nursing home rates.

COUNCIL ON MEDICAL ECONOMICS

Committee on Health Insurance—The Board authorized the Committee on Health Insurance to invite input from Blue Shield and to consult Blue Shield on problems when necessary. The Board also approved a communication to the membership advising that the Committee on Health Insurance is concerned with any problems involving Blue Shield and other third party carriers. (Filed—R.C. V)

Revision of the 1971 RVS—The Board approved the use of coding and nomenclature of the California Relative Value Studies in the revision of the 1971 Florida Relative Value Studies and authorized the Council on Medical Economics and its Committee on Relative Value Studies and Fee Schedules to negotiate in any way they deem necessary to expedite the revision of the 1971 Florida Relative Value Studies.

Cosmetic and Reconstructive Surgery

RECOMMENDATION NO. 9

The Board of Governors recommends to the House of Delegates adoption of the amended definitions of cosmetic and reconstructive surgery as recently defined by a Blue Shield task force as the definitions recognized by the FMA:

"Reconstructive surgery is defined as surgery attempting to improve function or appearance to any area of the body which is altered by disease, trauma, or congenital deformity as opposed to familial characteristics, or aging phenomena."

"Cosmetic surgery is defined as surgery performed solely to improve the appearance of the individual but not to restore bodily function or correct deformity. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons."

Peer Review of the Private Health Insurance Sector—The Board authorized the Committee on Health Insurance to proceed with development of the proposed contractual arrangement for peer review of the private health insurance sector in consultation and coordination with the Council on Medical Systems and with the approval of the Executive Committee. (Filed—R. C. V)

Fee for Vision Analysis—The Board concurred with the Council on Medical Economics and the Travelers Insurance Company that a fee differential for vision analysis is warranted because ophthalmologists perform a medical service while optometrists only perform refractive services. (Filed—R. C. V)

Workmen's Compensation Medical and Surgical Fee Schedule—Approval has been given by the Board for the Florida Medical Association to contact the Florida Department of Commerce, Workmen's Compensation Bureau, to petition for hearings to update the Workmen's Compensation Medical and Surgical Fee Schedule. (Filed—R. C. V)

DHRS—Medical Fee Schedule—The Board has requested the Department of Health and Rehabilitative Services to update its medical fee schedule. (Filed—R. C. V)

COUNCIL ON MEDICAL SERVICES

State Drug Abuse Program—The Board of Governors approved an agreement between the Department of Health and Rehabilitative Services, Division of Mental Health and Florida Medical Foundation, for a $50,000 grant to the Foundation to conduct a review and evaluation of a number of residential drug abuse treatment centers in the State of Florida. The FMA Committee on Drug Abuse has been designated as the Steering Committee for this project.

Committee on Tele-Communications—The Association's Committee on Tele-Communications after extensive study has drawn up recommendations for tele-communications for Emergency Medical Services. This communications service will be strictly for medical services and is not to involve other public services.

RECOMMENDATION NO. 10

The Board of Governors recommends to the House of Delegates adoption of the following resolution regarding tele-communications:

Whereas, There is national interest and legislation in specialized tele-communications for emergency medical services and,

Whereas, The State of Florida has enacted a Law (73-254) requiring the establishment and regulation of emergency medical tele-communications, therefore be it

RESOLVED,

1. That the Florida Medical Association endorse active participation by this association and its component medical societies in the development of emergency medical services regional tele-communications plans and subsequent operations.
2. That an ad hoc committee be created to develop funding techniques that will ensure the development of an effective voice in this matter without jeopardy to resources of the Florida Medical Association or its component societies.

CPR Training—The Board of Governors endorsed the need for cardio-pulmonary resuscitation (CPR) training for all physicians, and agreed to request the county medical societies to assist their membership in upgrading their CPR skills.

Categorization of Emergency Facilities—The Board of Governors authorized a study of categorization of emergency facilities and the development of appropriate recommendations.

Florida Committee on Rural Health—The Board concurred in the recommendation that the Florida Medical Association continue to maintain membership in the Florida Committee on Rural Health through the FMA Committee on Rural Health.

COUNCIL ON MEDICAL SYSTEMS

PSRO—The Board endorsed the action of the Escambia County Medical Society to (1) establish an acceptable alternative mechanism to PSRO for peer review and (2) attempt to delineate a more acceptable geographic division of PSRO area number one. (Filed—R. C. V)

PRO—The House of Delegates at its meeting in May, 1974 and again at its called meeting December 16, 1974 directed that the FMA reject the PSRO substitute for peer review and that future legislative efforts be made to develop a system more closely approaching peer medical utilization review.

The Board approved:

(a) The proposed approach to establishment of a statewide professional review organization (PRO) with pilot projects in several areas as indicated
(b) Designation of Council on Medical Systems as a steering committee for statewide PRO planning and activities.
(c) Coordination of the efforts of the pilot areas to allow development of a PRO system which can be adapted (1) to all portions of the state as needed and (2) to all types of medical services (i.e., private, Medicare, Medicaid, HMO, etc.) (Filed—R. C. V)

FMF (PRO) Peer Review-Medicaid—The Board authorized continued negotiations for implementation of an agreement between the Florida Medical Foundation and the Department of Health and Rehabilitative Services for professional peer review for Florida Medicaid Program. Under the agreement the Foundation would:

1. Establish and maintain the treatment criteria which will be used in the automated screening of claims for medical review.
2. Develop and operate a statewide peer review system capable of providing the following medical review for all Medicaid services covered by the agreement:
   a. Admission certification and on-going review for acute care general hospitals (concurrent reviews).
   b. Pre-payment claims review for claims screened for review by the computer.
   c. Retrospective review of management and utilization reports to recommend program improvements, and to develop professional education programs. (Filed—R. C. V)

Quality of Care Assessment—The Board approved a grant from the FRMP to the Florida Medical Foundation to conduct an educational program for physicians in peer review techniques.

Essentially, the project is designed to assess the present state of the art in medical peer review techniques and methodologies available in Florida and based on this information, conduct regional seminars and education workshops for community physicians in medical peer review organization. The goal of the project is to lay the foundation for a separate statewide professional review organization. (Filed—R. C. V)

Hillsborough Foundation—The Board granted FMA approval as a recognized foundation for medical care to the Professional Foundation for Health Care, Inc. of Hillsborough County. (Filed—R. C. V)

COUNCIL ON SCIENTIFIC ACTIVITIES

The Board concurred in the recommendation that the AMA Physician's Recognition Award at this time not be considered as a replacement for the current FMA continuing medical education requirements for all members, but that the Committee on Continuing Medical Education study the possibility of implementing the AMA Physician's Recognition Award as of January 1, 1977 (end of the first three-year cycle), or if the FMA's CME program becomes too complicated or costly to continue.

Scientific Exhibitors—The Board agreed that scientific exhibitors at the Annual Meeting should be available continuously at their exhibits during visiting hours, and requested the Council on Scientific Activities, through its Committee on Continuing Medical Education, to give consideration to CME credit hours for time spent in preparing and showing a scientific exhibit.

CANDID PHOTOGRAPHS. . .

(Top, left to right) Dr. Warren W. Quillian, Coral Gables, Mrs. Jere W. Annis, Lakeland and Mrs. Quillian; Dr. Jere W. Annis, Mrs. Annis and W. Harold Parham, DHA, Jacksonville, Executive Vice President of the Florida Medical Association. Second row: Dr. and Mrs. William J. Dean, St. Petersburg; Dr. and Mrs. Vernon B. Astler, Boynton Beach and Dr. and Mrs. Thad Moseley, Jacksonville; Mrs. Daniel B. Nunn, daughter, Myra Beth and Dr. Nunn, Jacksonville.
Third row: Dr. and Mrs. H. Phillip Hampton, Tampa; Dr. and Mrs. Eugene G. Peek, Ocala; Dr. and Mrs. George S. Palmer, Tallahassee.
Fourth row: The man in the sensuous shirt and curly top could be no other than Dr. Samuel M. Day of Jacksonville. The lady is Mrs. Thad Moseley of Jacksonville, wife of the outgoing President. Fifth row: Dr. Jack Q. Cleveland, Coral Gables; Dr. Joseph C. Von Thron, Boynton Beach; Dr. Malcom Todd, Long Beach, Calif.; and W. Harold Parham, DHA, Jacksonville.

MORE CANDID PHOTOGRAPHS. . .

(Top—left to right) Dr. and Mrs. Russell Forlaw, Boynton Beach; Rep. John R. Forbes, Jacksonville, Mrs. Forbes and daughters chat with Dr. Ray E. Murphy of Pompano Beach; Dr. Carl E. Andrews, West Palm Beach and Dr. Donald C. Nikolaus, Dunedin; Dr. and Mrs. Richard M. Fleming, Miami; Mr. Roger Wise, Jacksonville; Mrs. Gerold L. Schiebler, Gainesville and Mr. James P. McLean, Gainesville; Drs. Charles A. Stump and Richard W. Snodgrass, Daytona Beach and wives; Dr. C. Rollins Hanlon, Chicago and Dr. Thad Moseley, Jacksonville; Dr. Frank C. Coleman, Tampa; Dr. and Mrs. Robert N. Webster, Tallahassee; Dr. and Mrs. John R. Browning, Jacksonville and Dr. Astler. Second row (left to right) Dr. and Mrs. Paul A. Tanner, Auburndale chat with Dr. Moseley; Mrs. Irving Essrig, Tampa; Mrs. Robert E. Windom, Sarasota and Mrs. Linus W. Hewitt, Tampa; Mrs. Vernon B. Astler, Boynton Beach and Mrs. Burns A. Dobbins, Fort Lauderdale; Dr. Eugene G. Peek of Ocala gives Mrs. James J. DeVito of St. Augustine, a warm greeting; Dr. Dick Van Eldik, Lake Worth; Dr. Rufus K. Broadaway, Miami; Mrs. Eugene G. Peek, Ocala and Mrs. William J. Dean, St. Petersburg; Dr. Heinz J. Wittig, Gainesville; Dr. W. Reed Bell, Pensacola and Dr. Henry M. Yonge, Pensacola; Dr. Michael J. Pickering, Lakeland and Dr. Henry J. Babers, Gainesville; Dr. Malcolm Todd, AMA President, Long Beach, Calif.; Dr. Warren W. Quillian, Coral Gables and Dr. Jere W. Annis, Lakeland; Dr. Chandler A. Stetson, Vice Presi-

FROM THE 101st FMA ANNUAL MEETING

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dent and Dean, University of Florida College of Medicine, Gainesville; Dr. Gerold L. Schiebler, Gainesville and Mr. James P. McLean, Gainesville. Third row (left to right) Dr. F. Norman Vickers, Pensacola enjoying taking pictures; Dr. and Mrs. Ray E. Murphy, Pompano Beach and Dr. Irving Essrig, Tampa; Dr. Curtis D. Benton, Fort Lauderdale receiving an award as outgoing president of the Florida Society of Ophthalmology from incoming president, Dr. John W. Glotfelty, Lakeland; Dr. Charles P. Hayes, Jacksonville and Dr. Yank Coble, Jacksonville; Dr. James W. Walker, Jacksonville, FMA Secretary; Dr. and Mrs. Jack MaCris, St. Petersburg and Dr. and Mrs. Thad Moseley, Jacksonville; Rep. John R. Forbes, Jacksonville and Dr. J. Gerard Converse, Winter Haven; Dr. Robert E. Windom, Sarasota; Cong. Paul Rogers, West Palm Beach and Dr. John W. Glotfelty, Lakeland; Rep. Forbes and Dr. Vernon B. Astler. Fourth row (left to right) Dr. Joseph C. Von Thron, Cocoa Beach and Dr. Jack MaCris, St. Petersburg; Delegates from Escambia County Dr. Eric F. Geiger; Dr. C. Fenner McConnell; Dr. Henry M. Yonge; Dr. Philip B. Phillips and Dr. William M. C. Wilhoit, all from Pensacola; Mr. Ernest Currie, Executive Director, Duval County Medical Society, Jacksonville; Dr. Thomas S. Edwards, Jacksonville and Dr. John C. Fletcher, Tampa; Dr. and Mrs. Fred I. Dorman, Lakeland; Dr. and Mrs. C. Brooks Henderson, Ocala; Mrs. Joseph C. Von Thron, Cocoa Beach and Dr. William J. Dean, St. Petersburg; Dr. and Mrs. John J. Cheleden, Ormond Beach.

HIGHLIGHTS

Woman's Auxiliary Annual Meeting

(Top, left to right) FLAMPAC sign for Woman's Auxiliary luncheon; Mrs. Howard Liljestrand of Honolulu (right), President of the Woman's Auxiliary to the American Medical Association, was a guest of honor at the annual convention of the Woman's Auxiliary to the Florida Medical Association. Here she shares a moment with Mrs. Ray Murphy of Pompano Beach, President of WA/FMA; Mrs. C. Brooks Henderson, Ocala receives the gavel from Mrs. Murphy as incoming WA president; Mrs. Murphy addresses one of the Auxiliary sessions. Second row (left to right) Auxiliary member Mrs. Thomas Roberts receives the Peggy Wilcox Award from Mrs. Malcolm Miller, WA/FMA Recording Secretary; Incoming President Dr. Vernon B. Astler departs from the serious business to share a smile with the Woman's Auxiliary; U.S. Senator Robert J. Dole, Kansas, reaches a light moment in his address at the annual Woman's Auxiliary FLAMPAC luncheon. Third row (left to right) Mrs. James J. DeVito, St. Augustine, displays her Archives and History sign; Mrs. Murphy and Sen. Dole; Mrs. Howard Liljestrand, Honolulu, President of the Woman's Auxiliary to the American Medical Association and Mrs. William H. Harrison, Daytona Beach. (Bottom) New FMA President Vernon B. Astler, M.D., finds his new job can be a fun thing when he visited one of the business sessions of the Auxiliary (left to right) Mrs. Edward Slosek, Dr. Astler, Mrs. C. Brooks Henderson, Mrs. Michael J. Foley, Mrs. Thomas B. Thames, Mrs. John T. Blackburn, Mrs. Terry F. Tanner, Mrs. R. B. Moore, Mrs. B. David Epstein, Mrs. William H. Harrison, Mrs. James L. Stone and Mrs. Fred P. Swing.

FMA Journal—The Board acknowledged the excellent contribution of the *Journal of the Florida Medical Association* to many FMA activities, and expressed continued support of the *Journal* so as to make possible the publication of a superior *Journal;* with the understanding that this will be done within the limits of the budget.

The Board commended Clyde Collins, M.D. for his outstanding work as Editor of the *Journal of the Florida Medical Association,* and expressed appreciation to Dr. William M. Straight, Historical Editor, the Staff, and the contributors for the outstanding work they did in publishing the Centennial issue of the *Journal of the Florida Medical Association, Inc.,* January, 1974.

Collective Bargaining

RECOMMENDATION NO. 12

The Board of Governors recommends to the House of Delegates adoption of the following resolution pertaining to collective bargaining legislation as to its effect on the three medical schools:

That the medical facilities of the State University System should not be included in any statewide bargaining unit inasmuch as they represent a service group of professionals with marked variance in purpose and vocational activity from other employee groups within the State of Florida.

Their inclusion in a larger bargaining group would be most detrimental to the current high quality of medical education and delivery of health care to the citizens of the State of Florida.

School of Optometry

RECOMMENDATION NO. 13

The Board of Governors recommends to the House of Delegates that the FMA reemphasize its policy that there is no demonstrable need at the present time for a separate school of optometry. Furthermore, if the need for training such individuals in Florida can be documented in the future, such training could be carried out more economically by utilizing the existing education programs and resources within one of the departments of ophthalmology at one of Florida's medical schools.

COUNCIL ON SPECIALTY MEDICINE

RECOMMENDATION NO. 14

[Referred back to Board of Governors for further study by the Council on Specialty Medicine R. C. I]

The Board of Governors recommends to the House of Delegates approval of the following resolution on diagnosis and treatment of mental or emotional disorder for the Florida Division of Vocational Rehabilitation by "physicians as presented by the Council of Florida District Branches of the American Psychiatric Association:

Whereas, The federal vocational rehabilitation regulations have been promulgated regarding the diagnosis and treatment of mental or emotional disorders by licensed or certified psychologists, and

Whereas, It is recognized that some mental and emotional disorders may be treated effectively by mental health professionals other than psychiatrists and some disorders require the special skills of the psychiatrist in both diagnosis and treatment, and

Whereas, Negotiations between the American Psychiatric Association, American Psychological Association and other national organizations have been established to determine guidelines for diagnosis and treatment, therefore, be it

RESOLVED, That the Florida Division of Vocational Rehabilitation be strongly urged to continue its established practice of diagnosis and treatment of mental and emotional disorders by physicians (psychiatrists when available) until those guidelines are established by said national organizations.

Criminal Acts and Psychiatry—The Board agreed to appoint a task force and invite the Florida Bar Association to do the same, and that the two groups study and work out recommendations for their parent organizations and the Legislature regarding criminals being declared insane before their trial for criminal acts.

Medical Service Projects

RECOMMENDATION NO. 15

The Board of Governors recommends to the House of Delegates adoption of the following criteria for FMA endorsement of medical service projects by lay groups:

1. Local county medical societies are to be notified of the plans and approval by the local medical society must be obtained.

2. Medical supervision by a Florida licensed medical doctor is necessary who must be a member of the Florida Medical Association.

3. No charge for services rendered is to be made, however donations may be accepted for the services rendered.

4. Information on individuals receiving the service is the responsibility of the

individual to convey personally to their personal physician or approved health agency or clinic.

School of Optometry—The Board of Governors designated the Florida Society of Ophthalmology and Committee on Medical Education to serve as the consultative body within the FMA in regard to the establishment of the location and organization of the School of Optometry in the state. (Amended—R.C. I)

Recognition of Specialty Groups—The Board of Governors approved the applications of the Florida Association of Pediatric Cardiologists, the Southeast Chapter of the Society of Nuclear Physicians, and the Florida Endocrine Society for recognition by the FMA as specialty groups.

RECOMMENDATION NO. 16

After careful consideration, the Board of Governors submits the following recommendations to the House of Delegates for amendment to the FMA By-Laws.

Special Meetings of the Association: Two Amendments

CHAPTER II—MEETINGS, Section 2—Special Meetings

Amend by:
Deleting the words, "FIFTY ACTIVE MEMBERS OF THE ASSOCIATION" and replacing them with the words, "10% OF THE TOTAL ASSOCIATION MEMBERSHIP."

CHAPTER IV—HOUSE OF DELEGATES, Section 3—Called Meeting

Amend by:
Deleting the words, "FIFTY ACTIVE MEMBERS OF THE ASSOCIATION" and replacing them with the words, "10% OF THE TOTAL ASSOCIATION MEMBERSHIP."

Called Meetings of the House of Delegates

CHAPTER IV—HOUSE OF DELEGATES, Section 3—Called Meeting [Not Adopted—R.C. III]

Privilege of the Floor at the House of Delegates

CHAPTER IV—HOUSE OF DELEGATES, Section 14—Privilege of Floor

Amend as follows:
Insert after the word "Officers" on line 2 of Section 14, "PRESIDENTS OF THE COUNTY MEDICAL SOCIETIES."

Section 14 would then read: "The privilege of the floor shall be restricted to seated Delegates. Officers, PRESIDENTS OF THE COUNTY MEDICAL SOCIETIES, members of the Board of Governors, AMA Delegates, Past Presidents, members of the Council on Specialty Medicine, Council Chairmen, and AMA Past Presidents who are FMA members, except by permission of the Presiding Officer.

This privilege includes the right to make motions, provided they are seconded by a voting member of the House."

FMA Council on Committee Activities

CHAPTER VIII—COUNCILS, Section 2—Composition, Selection and Appointment to Fill Vacancy

Amend by adding:
"COUNCILS SHALL BE COMPOSED OF THE CHAIRMAN OF THE COMMITTEES ASSIGNED TO THAT COUNCIL PLUS THE CHAIRMAN AND VICE-CHAIRMAN APPOINTED BY THE PRESIDENT."

Proration of Dues

CHAPTER X—INCOME AND EXPENDITURES, Section 2—Dues Item 4—Proration of Dues

Amend the first paragraph to read:
"New members who join the Association on or after July 1 BUT PRIOR TO OCTOBER 31 of any year shall be required to pay dues for one-half of that year only in addition to the entrance fee. NEW MEMBERS WHO JOIN THE ASSOCIATION AFTER THE CLOSING DATE OF OCTOBER 31 SHALL BE REQUIRED TO PAY AN ENTRANCE FEE BUT SHALL NOT BE REQUIRED TO PAY PRORATED DUES FOR THE REMAINDER OF THE CURRENT YEAR."

Dues-Delinquency

CHAPTER X—INCOME AND EXPENDITURE, Section 2—Dues Item 5—Delinquency

Amend to read:
"An Active or Associate Member whose annual dues have not been received by the Association through his component society on or before April 1 of the current year shall be considered delinquent. He shall be notified of such delinquency by the Secretary of the Association by notice mailed to his last known address. If payment has not been received on or before OCTOBER 31 of that year, he shall be summarily removed from the membership roll of the Association."

Supplemental Report Board of Governors

Upon recommendation of the Reference Committee the Supplemental Report of the Board of Governors was adopted as printed.

Supplemental Report Board of Governors

THAD MOSELEY, *Chairman*

This supplemental report to the House of Delegates includes several items of major importance which have been acted upon since the initial report of the Board of Governors to the House of Delegates was completed, and to make any corrections which may be necessary to the original report.

Professional Liability Insurance—In its initial report to the House of Delegates the Board of Governors reported its unanimous decision that upon breach of the contract by Argonaut Insurance Company, the FMA would enter suit in the appropriate court and pursue this breach of contract as vigorously as possible.

The Argonaut breached the contract when it billed 6,000 FMA members that they insure on March 10, 1975 for 95% additional premiums effective March 15, 1975 in two installments—35% by April 1, 1975 and the remaining 65% by July 1, 1975. The State Insurance Commissioner ordered an emergency ruling on March 14, 1975 advising Argonaut on March 17, 1975 to rescind its request for additional premiums. There has been no court ruling to sustain the Commissioner's order. The Argonaut sued the FMA in Federal Court on March 12, 1975 in an

attempt to be released from its 5-year contract to provide coverage at predetermined rates for FMA members. In a counterclaim, the FMA is seeking a preliminary injunction in the Federal Court to prevent the Argonaut from increasing its premium and terminating policies or cancelling them. In a hearing before Judge Gerald G. Tjoflat on April 7, the FMA was able to gain a stipulation from the Argonaut that it will not cancel individual policies for failure to pay the April 1 premium increase until April 25. Any cancellation notices received by physicians covered under the program will not be effective before that date and any physician who has paid the premium but was subsequently cancelled will be reinstated.

The FMA countersuit against Argonaut has been converted to also include a class action on behalf of individual members insured under the FMA-Argonaut program. All insured doctors will be considered participants in the class action unless they have advised the court in writing by April 19, 1975.

A legal proceeding in Judge Tjoflat's court to consider the enforceability of the contract was scheduled for Monday, April 21. The Judge has advised that he will rule on enforceability of the contract no later than April 25 which is the date stipulated by the Argonaut for its termination of policies.

The FMA has continued its efforts to achieve essential legislative relief that will enable the Association to organize a medical liability mechanism to provide professional liability insurance coverage for its members.

Financial Statement and Budget—Copies of the CPA audit of the finances of the Association are available to the appropriate reference committee of the House of Delegates and are on file in the Association's headquarters office for review by members of the FMA.

This information was inadvertently deleted from the item in the Board of Governors report dealing with the financial statement and budget.

Florida Physicians Association Annual Report—The Board of Governors at its March meeting discussed the Annual Report of the Florida Physicians Association which is printed in the Delegates' Handbook. The Board was concerned about making public disclosure of the membership of this organization as indicated on lines 28-32 of the report and recommends to the Reference Committee that membership figures be deleted from the report and not be printed in the proceedings of the House.

Nominations-Committee on Membership and Discipline—The Board of Governors wishes to submit to the House of Delegates an amendment to the nominations made to the House for the Committee on Membership and Discipline by changing the nominee for District 9 (78) to read "Hector R. Mendez, M.D." in lieu of "W. Dean Steward, M.D."

Workmen's Compensation Medical and Surgical Fee Schedule—In its report to the House, the Board of Governors advised that authorization had been given for the FMA to petition the Bureau of Workmen's Compensation, Department of Commerce, for hearings on updating the Workmen's Compensation Medical and Surgical Fee Schedule. This petition was filed on April 8, 1975 requesting that a hearing be held at the earliest possible date and that the Florida rules of civil procedure be appropriately revised to incorporate in its Medical and Surgical Fee Schedule the 1971 Florida Relative Value Schedule and the recommended revised conversion factors.

Medicine	*Surgery*	*Radiology*	*Pathology*
.84	38.39	3.80	.39

President's Address

The Reference Committee noted the President's Address with great interest and applauded the President for his outstanding leadership during the past year.

Upon recommendation of the Reference Committee the President's Address was adopted and appears on page 23 of this issue.

Remarks of the Speaker

The Reference Committee reviewed the address of the Speaker and notes with pride the effective manner in which the Speaker has conducted the business of the House.

Upon recommendation of the Reference Committee the remarks of the Speaker were adopted as presented and appear on page 29 of this issue.

Report of Board of Governors Representative from State Board of Medical Examiners

Upon recommendation of the Reference Committee the report of the Board of Governors Representative from the Florida State Board of Medical Examiners was filed for information.

Report of Board of Governors Representative from Florida State Division of Health

Upon recommendation of the Reference Committee the Report of the Board of Governors Representative from the Florida State Division of Health was filed for information.

Report of Committee on AMA Delegates

Upon recommendation of the Reference Committee the Report of the Committee on AMA Delegates was filed for information.

Report of the Florida Medical Foundation

Upon recommendation of the Reference Committee the Report of the Florida Medical Foundation was filed for information.

Report of the Florida Physicians Association, Inc.

The Reference Committee recommended that the Report of the Florida Physicians Association, Inc., as previously amended by adoption of the Supplemental Report of the Board of Governors, be filed for information.

The report was filed.

Judicial Council*

Resolution 75-36*
Telephone Listing

George T. Singleton, M.D.

*Editor's note: These items considered at Third House of Delegates.

The Reference Committee indicated that it had considered the report of the Judicial Council at length and testimony was heard from interested physicians on Item No. 6, Telephone Directory Listings and Resolution 75-36, Telephone Listing. The Reference Committee recommended that the portion of the Judicial Council report entitled, "Telephone Directory Listings" be referred to the Board of Governors for further indepth study in the hope that a comprehensive policy could be developed which will be appropriate for our own state medical association's aims and needs and recommended that the obvious solution appears to be limiting listings to specialties that have certifying boards and that listings should be limited to those eligible and/or certified.

The Reference Committee also recommended that Resolution 75-36 not be adopted.

A motion was made from the floor to modify these recommendations by adding: "That while the entire issue is being referred to the Board of Governors for definitive action, that the Florida Medical Association revert to the guidelines for telephone directory listings that existed prior to the appearance of the so-called approved AMA listing of specialties.

A point of order was called in that the House was considering three recommendations at one time.

The Speaker, Dr. Murray, suggested that the House recess for the day and resume the consideration of these recommendations on Sunday to allow the Reference Committee and members of the House of clarify the recommendations.

Upon motion duly carried the Second Meeting of the House of Delegates recessed at 5:40 p.m.

Other than being physicians, these three men have another common bond. They are the deans of Florida's three medical schools. Left to right: Donn L. Smith, M.D., Tampa, University of South Florida; Emanuel M. Papper, M.D., Miami, University of Miami; and Chandler A. Stetson Jr., M.D., Gainesville, University of Florida.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:15 a.m. on Sunday, April 27, 1975, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Dr. Louis C. Murray, Speaker of the House, presiding.

Dr. William Straight of the Credentials Committee reported 208 delegates registered and 38 counties represented, constituting a quorum.

Dr. Straight moved that the delegates be seated.

The motion carried.

Delegates

ALACUHA—O. Frank Agee, Henry J. Babers, George J. Caranasos, Stanley I. Cullen, William B. Deal, Arthur A. Mauceri.
BAY—B. Phillip Cotton, John Mason.
BREVARD—Lewis Bean, James E. Carter, Michael J. Foley, T. John Kaminski, Pat B. Unger.
BROWARD—C. H. Bechert, M. J. Bielek, R. J. Brennan, B. B. Burgess, A. S. Capi, B. A. Dobbins, F. G. Gieseke, T. W. Hahn, J. A. Jordan, W. B. King, D. C. Lane, G. P. Messenger, R. E. Murphy, F. B. Ott, J. B. Perry, T. F. Regan, D. M. Seropian, N. J. Skaja, R. E. Talley (Absent—R. L. Andreae, R. B. Carson, W. D. Wells).
CAPITAL—R. P. Johnson, N. H. Kraeft, J. W. MacDonald, R. N. Webster.
CHARLOTTE—Melvyn Katzen, Fred P. Swing.
CITRUS-HERNANDO—W. Randall Jenkins.
CLAY—Laurin G. Smith.
COLLIER—William Bailey, Fred Butler.
COLUMBIA—Frank E. Adel.
DADE—W. G. Aten, Jerome Benson, Jerome Block, Rufus K. Broadaway, Manuel Carbonell, Richard C. Clay, Jack Q. Cleveland, Vincent Corso, John Cunio, O. William Davenport, Joseph Davis, Richard Dever, J. Lee Dockery, Charles Dunn, Isaac Egozi, R. W. Elkins, Franklin J. Evans, A. Fernandez-Conde, Joseph Fitzgerald, Ivor Fix, Richard Fleming, L. Marshall Goldstein, Pedro J. Greer, Julian Groff, Leo Grossman, Marshall Hall, Joseph Harris, Stanley Holzberg, Walter C. Jones Jr., Walter C. Jones III, James Jude, Robert Katims, Harold Kaufman, Josephine Kouri, Banning G. Lary, Maurice Laszlo, Warren Lindau, Carlos Llanes, Ronald Mann, Stanley Mitchell, Charles A. Monnin, Miguel Mora, Thomas Noto Jr., Robert J. Schiess, Janice Sherwood, Everett Shocket, Ruth A. R. Simons, Chauncey M. Stone Jr., Mario Stone, S. Peter Stokley, William Straight, Maynard Taylor, John Turner, Thomas B. Turner, Edgar W. Webb, Robert Willner, Elliot Witkind, Sheldon Zane (Absent—Bruce Miller, Modesto Mora, Daniel Seckinger, J. Vanden Basch).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Wilbert L. Dawkins Sr., Joe C. Ebbinghouse, Emmet F. Ferguson Jr., William T. Haeck, Charles P. Hayes Jr., John C. Kruse, Sanford A. Mullen, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander, William D. Walklett (Absent—William J. Garoni Jr., Robert K. Middlekauff).
ESCAMBIA—Eric F. Geiger, C. Fenner McConnell, Philip B. Phillips, W. M. C. Wilhoit, Henry M. Yonge.
FRANKLIN-GULF—Joseph P. Hendrix.
HIGHLANDS—Donald C. Hartwell.
HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Richard Connar, Irving M. Essrig, John C. Fletcher, Carlisle Hewitt, Richard S. Hodes, Victor Knight, Joel Mattison, Thomas E. McKell, Ralph M. Stephan, William W. Trice, Harold L. Williamson.
INDIAN RIVER—James E. Copeland Jr., Broadus F. Sowell.
LAKE—B. F. Brokaw, Thomas Weaver.
LEE—Larry Garrett, Stewart Hagen III, F. Lee Howington.
MADISON—(Absent—William J. Bibb).
MANATEE—Sanford Elton, John D. Lehman, Roger A. Meyer.
MARION—Henry L. Harrell Sr., C. Brooks Henderson.
MARTIN—John F. Powers (Absent—Richard Q. Penick).
MONROE—(Absent—Jerrold J. Weinstock, William M. Whitley).
NASSAU—(Absent—Cecil B. Brewton).
OKALOOSA—William W. Thompson (Absent—David Arrowsmith).
ORANGE—Norman F. Coulter, William F. Eckbert Jr., Edward L. Farrar Jr., Clarence M. Gilbert, Paul C. Harding, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, Franklin G. Norris, Lester C. Nunnally, Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo.
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Vernon B. Astler, Curtis W. Cannon, George L. Ford, J. Russell Forlaw, Doris E. Lake, Richard B. Moore, Reginald Stambaugh Arthur Trask, Dick L. Van Eldik, Howard Willson (Absent—Charles Metzger).
PANHANDLE—Herbert E. Brooks (Absent—William F. Brunner).
PASCO—(Absent—M. L. Saperstein).
PINELLAS—Charles K. Donegan, Irwin L. Entel, John M. Hamilton, Walter W. Hamilton, Daniel S. Hellman, David S. Hubbell, Roger A. Laughlin, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, James M. Stem, Richard C. Trump, Walter H. Winchester, Rowland E. Wood.
POLK—Sam J. Barranco, Marvin G. Burdette, T. M Caswall, J. G. Converse, John W. Glotfelty, W. E. Manry Jr., Frank Zeller Jr.
PUTNAM—Charles E. Barrineau.
ST. JOHNS—W. Wayne O'Connell.
ST. LUCIE-OKEECHOBEE—H. C. McDermid.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas R. Murphy, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—John Johnson, Clyde Meade.
SUWANNEE-HAMILTON-LAFAYETTE—L. V. Radkins.
TAYLOR—John H. Parker Jr.
VOLUSIA—Thomas W. Ayres, O. B. Bonner, James A. Carratt, Richard W. Snodgrass, Thomas L. Wells.
WALTON—(Absent—Howard Currie)
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER OF THE HOUSE—Charles J. Kahn.

The Speaker asked the President, Dr. Moseley, to present a special guest.

Dr. Moseley introduced Dr. Malcolm Todd, President of the AMA, and asked that he present a few remarks to the House.

Obviously talking shop are FMA President Thad Moseley, M.D. (left) and AMA President Malcolm C. Todd, M.D., Long Beach, Calif., who visited the FMA annual meeting briefly on the final day.

Dr. Todd commended the Florida Medical Association for the achievements they have accomplished in the way of professional liability legislation. Dr. Todd outlined the steps being taken by the AMA to resolve the malpractice problem, stating the AMA had advocated the Joint Underwriting Association that would be self-destructing in two years' time, allowing for every doctor to have coverage. The AMA has sent to the component medical societies model legislation for use as guidelines; has a long range plan of formation of a medical accident liability commission which would consist of physicians, attorneys and laymen and would act as a mediation board for disputed claims; and is making plans for a physician owned mutual company to be operated by professionals.

Dr. Todd commended the Florida delegation to the AMA on the fine work they are doing, with special commendation to Dr. Jere Annis and Dr. Rufus Broadaway.

Dr. Todd continued, "The American Medical Association has introduced their National Health Insurance Bill in the Congress. We are not reintroducing medicredit." He indicated that the new bill was a much better one. He further indicated that the AMA is opposed to any legislation that would require compulsory health insurance.

Dr. Todd expressed his opinion that no National Health Insurance Bill would go through the Congress in 1975.

In conclusion, Dr. Todd stated that the AMA would continue to pursue their suit against the Department of HEW on utilization and review regulations and possibly the maximum allowed cost of drugs, or the Mack Program would be taken into court.

Dr. Todd stated that with the Planning Bill too much authority had been placed in the hands of the Secretary of HEW and that the practice of medicine was being made into a public utility. He ended by stating that the AMA totally disapproves of federal intervention into the practice of medicine.

Reference Committee No. III, Continued

The Speaker, Dr. Murray, resumed the Chair and called for Reference Committee No. III to come forward to continue their report.

The motion was made and seconded to reconsider Reference Committee III's recommendation pertaining to Telephone Directory Listings in the Report of the Judicial Council.

The motion carried.

Judicial Council

A motion was made and seconded to delete the portion of the recommendation of Reference Committee III, Report of the Judicial Council, Telephone Directory Listings, immediately following the words "indepth study."

The motion carried.

The recommendation of the Reference Committee that the portion of the Judicial Council Report entitled, "Telephone Directory Listings" be referred to the Board of Governors for further indepth study was adopted as amended.

Resolution 75-36
Telephone Listing
George T. Singleton, M.D.

Upon recommendation of the Reference Committee Resolution 75-36 was not adopted.

Statewide Standards for Newspaper Announcements
Resolution 75-7
Standards for Newspaper Announcements
Dade County Medical Association

Upon recommendation of the Reference Committee the portion of the Judicial Council Report entitled, "Statewide Standards for Newspaper Announcements" was adopted but the question of newspaper announcements was referred to the Board of Governors for continued study and clarification.

The Reference Committee recommended that Resolution 75-7 not be adopted.

A motion was made and seconded from the floor to adopt a substitute resolution for Resolution 75-7, Standards for Newspaper Announcements.

Substitute Resolution 75-7 was adopted.

Substitute Resolution 75-7

Standards for Newspaper Announcements

RESOLVED, That the "Statewide Standards for Paid Newspaper Announcements by Members of The Florida Medical Association, Inc." be considered minimum restrictive standards for newspaper advertising and that any county society may enact more restrictive standards if desired to suit the particular needs of their medical community.

Upon recommendation of the Reference Committee the Judicial Council Report was adopted as amended.

Judicial Council

VINCENT P. CORSO, *Chairman*

A variety of problems both major and minor has commanded the attention of your Judicial Council in the past year. Some were disposed of quickly; others required attention for a longer period of time.

The Council's first meeting of the year was called to order on May 12 at the conclusion of the 1974 House of Delegates. Other meetings were conducted on September 21-22, 1974, and on January 24, 1975.

The death of Nelson Zivitz, M.D., Miami Beach, injected a note of sadness into the Council's workyear. For many years, Dr. Zivitz served with honor and distinction as a member of this Council and as Chairman of its Committee on Membership and Discipline. On January 24, we received his successor, William M. Straight, M.D., of Miami, who has previously served on this Council.

Following is an itemization of many of the important matters with which your Council has been involved:

1. Joint Meeting with AMA Judicial Council: Your Council enjoyed the privilege of meeting for a half-day on September 21, 1974, with the Judicial Council of the American Medical Association in Kissimmee, Florida. The two tribunals engaged in an in-depth discussion on such issues as: charging of interest on overdue medical service accounts; acupuncture; acquisition of medical practices by lay corporations; ear piercing; the definition of the practice of medicine; and the obligations of physicians who encounter objections, on religious grounds, from parents for whose children blood transfusions are recommended.

2. Liaison with Osteopathy: The 1974 House of Delegates abolished the Ad Hoc Committee on Liaison with Osteopathy and assigned its functions to the Judicial Council. John J. Cheleden, M.D., is the Council's principal liaison officer with the Florida Osteopathic Medical Association. He, your Chairman, and other FMA representatives met with the Executive Committee of the FOMA in Daytona Beach on December 7, 1974. The agenda included discussion of FMA-sponsored legislation to create a separate state department of health services headed by a physician; FMA's professional liability insurance bills that are to be filed in the Legislature this year; and the FMA-initiated Compact for Continuing Medical Education.

Another meeting with the osteopathic delegation was contemplated for some time in March before the convening of the 1975 Legislature.

3. Medicine and Religion: The 1974 House of Delegates assigned to this Council responsibility for medicine and religion activities. The press of other business has forced the Council to lay this important program aside temporarily, but hopefully, some activity can be undertaken in this area during the coming year.

4. Quackery: The old Subcommittee on Quackery was abolished by the 1974 House of Delegates, and the Judicial Council inherited its duties. The Council representative assigned to this function has kept himself informed of problems in this area, but there is no significant activity to report at this time.

5. Associate Membership: At the request of the Executive Committee, the Council studied the requirements for and the definition of "Associate Membership" in the Florida Medical Association By-laws. An appropriate recommendation has been forwarded to the Board of Governors. It suggests that generally, associate membership be limited to unlicensed physicians with the provision that the Board of Governors be authorized to grant exceptions. Complete revision of Section 2 (Classifications), Chapter I (Membership), for the purpose of clarification also is proposed.

6. Telephone Directory Listings: [REFERRED TO BOARD OF GOVERNORS FOR FURTHER INDEPTH STUDY.] A number of inquiries arising from the 1974 Statewide Standards for Telephone Directory Listings have been received, considered and ruled upon. Generally, these standards permit physicians who qualify to list themselves in telephone directory yellow pages under not more than two specialty or subspecialty headings. It was the intent of the 1974 House of Delegates to allow headings only for those specialties and subspecialties recognized by the American Medical Association and the Advisory Board for Medical Specialties.

Your Council has denied authorization of headings for specialties not specifically recognized. On this basis, your Council has declined approval for "facial plastic surgery" and "maxillo-facial surgery."

A county medical society which sought to substitute its own set of specialty listings in telephone directories published for its area likewise was turned down.

In response to other questions on this subject, your Council has held:

—That a physician need not be board certified or eligible to list himself under a *subspecialty* heading (e.g., hematology, pediatric allergy, etc.) provided he devotes a substantial portion of his practice to that subspecialty and provided that he is either board certified or devotes full time to a primary specialty.

—That a certified otolaryngologist may not list himself under "Surgery, Plastic" unless he is also board certified in plastic surgery.

—That a physician certified in thoracic surgery may also list himself under the heading "Surgery, Cardiovascular," if he does indeed devote a significant portion of his professional practice to that type of surgery.

Representatives of Southern Bell Telephone Company and General Telephone Company have indicated they wish to cooperate as much as possible with the FMA policy. However, both utilities must follow a standard "heading book" which is used throughout the system of each. Your Council has reviewed the medical and surgical specialty headings contained in the "heading books" which are virtually identical in the case of each of the two companies.

The two companies were asked to delete certain headings from their books. Some of these were for unrecognized specialties (e.g., adolescent medicine, obesity). Others involved specialties for which there is a preferred term (e.g., surgery, colon and rectum, instead of proctology). Your Council also suggested to the telephone companies that a revised set of specialty headings based

on the AMA Advisory Board of Medical Specialties list be substituted for the lists in their heading books. No commitment has been received.

7. Verification of Directory Listings: As a result of action by your Council, all county medical societies have been asked to offer their services to their telephone companies in verifying that physicians listed are licensed, prior to directory publication. It was learned that the telephone companies make little or no effort on their own to make such verifications. In 1973, the Attorney General of New York found that of all the individuals listed as physicians in the New York City Yellow Pages, 13 percent were not licensed. An American Medical Association check of the Greater Miami Directory turned up five names that could not be verified.

8. Statewide Standards for Newspaper Announcements: Like the policy on telephone directory listings, the newspaper announcement standards adopted by the House of Delegates in 1974 have generated some inquiries and misunderstanding. During the year, the Judicial Council rejected the Dade County Medical Association's request to be exempted from the standards; and the Hillsborough County Medical Association's request to impose its own restrictions. Both actions were taken on the grounds that the standards were the policy of the House of Delegates and could be changed only by the House.

Since the standards became effective, there has been a dramatic increase in physician professional announcements appearing in Florida newspapers. Most of these conform to the rules. Some are borderline violations and some are clear violations. In two cases, the Chairman of the Council communicated with physicians whose names appeared in improper announcements calling their attention to the violations. However, no disciplinary action was taken.

9. Integrated Bar of Medicine: At the request of the Board of Governors, your Council studied the concept of the so-called "integrated bar of medicine," which would organize the medical profession in Florida along the same lines as the Florida Bar. Subsequently, it was recommended to the Board of Governors that the FMA not support this concept. These alternate measures were suggested:

—That FMA support legislation specifically authorizing the Board of Medical Examiners to deputize any licensed physician for the purpose of conducting disciplinary investigations.

—That FMA support or sponsor an amendment to the Medical Practice Act broadening the authority of the Board of Medical Examiners to revoke, suspend, or otherwise restrict the license of a physician who in its judgment is not competent, or is intellectually or otherwise ill-equipped, to render proper medical care.

—That the FMA undertake a comprehensive study of the Medical Practice Act of Florida and all other laws relating to the practice of medicine; and of the capabilities and resources of the Board of Medical Examiners to enforce these laws.

10. Transfer of Medical Records: Among the most common type of complaints filed by patients against doctors is that which alleges refusal to forward medical records to other physicians. The Judicial Councils of both the FMA and AMA have held time and again that "it is unethical for a physician, who formerly treated a patient, to refuse, *for any reason*, to make his records of that patient promptly available on request to another physician. . . ." However, last year, in ruling on a Duval County Medical Society appeal from an FMA Judicial Council decision, the AMA Council added: "The Council has not said how records should be made available. Common sense and courtesy and the facts of the particular case will determine how a particular record is 'made available'."

Subsequently, your Council adopted the following statement for use in resolving grievances involving transfer of medical records from one physician to another:

> "It is unethical for a physician, who formerly treated a patient, to refuse, *for any reason*, to make his records of that patient available on request to another physician presently treating that patient. Common sense and courtesy and the facts of the particular case will determine how a particular record is 'made available'."

11. Definition of the Practice of Medicine: The Medical Practice Act, as it currently exists, defines the practice of medicine as follows:

> "Any person, except as hereinafter provided, shall be deemed to be practicing medicine within the purview of this chapter who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical or mental condition or who shall offer or undertake, by any means or method, to diagnose, treat, operate, prescribe for any human disease, pain, injury, deformity or physical or mental condition."

The law then lists several exceptions such as osteopaths and other disciplines regulated by other boards; any person rendering assistance in an emergency; domestic administration of recognized family remedies, government-employed physicians, etc.

With the rising popularity of jewelry store ear piercing, acupuncture, multiphasic screening, and life insurance and pre-employment examinations by lay persons, your Council would wonder whether the present definition of the practice of medicine is adequate. As an example, the Board of Medical Examiners some months back attempted to lessen the health risk to ear piercing by requiring that it be done under some sort of medical supervision. However, on March 7, 1974, Florida Attorney General Robert L. Shevin held that ear piercing does not fall within the definition of the practice of medicine.

Your Council hopes that if a survey of the Medical Practice Act is conducted as suggested in Item 9 above, it might yield a better definition in the light of present day circumstances.

12. Educationally Deficient Physicians: Your Council developed and sent to the Executive Committee for consideration "Judicial Council Guidelines for Improvement and Monitoring of Educationally Deficient Physicians." The purpose of these guidelines is to provide an orderly procedure for handling the cases of certain physicians whose practice indicates lack of attention to a good program of continuing medical education.

13. Acupuncture: The public continues to have an intense interest in acupuncture. FMA headquarters continues to receive both telephone and written inquiries, mostly from individuals wanting referrals to acupuncturists. In the absence of legislation on this subject, the State Board of Medical Examiners has ruled that acupuncture is the practice of medicine and must be done by qualified person under the supervision of a licensed physician. Nevertheless, the Florida Board of Chiropractic Examiners has published a rule permitting certain of its regulants to practice acupuncture in certain conditions.

This Council has recommended to the Board of Governors that the FMA support legislation limiting the practice of acupuncture to licensed doctors of medicine and doctors of osteopathy or properly trained non-physician personnel who work under the direct supervision of a physician.

14. Religious Objections to Blood Transfusions: Indepth discussions were conducted on the moral responsibilities of the physician who is refused parental permission for a blood transfusion of a minor child. The Council believes that neither legislation nor guidelines offer desirable solutions to these problems. It was pointed out that physicians should follow the Principles of Medical Ethics, and as a last resort, physicians always have access to the courts, which generally have been sympathetic to physicians and patients in such matters.

15. Community Medical Directories: Report C of the AMA Judicial Council (C-'74), subject: "Community Medical Directories," was reviewed by this Council, which concurred therein, to wit:

"It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations."

16. Interest Charge on Delinquent Account: There apparently is some growing sentiment that government dabbling in medicine and other influences have made passé the traditional proscription on the charging of interest on overdue doctor bills. The AMA Judicial Council budged slightly on this issue in its Report D (C-'74), subject: "Interest Charge on Delinquent Account." Your Council has considered this report and concurred therein, to wit:

"Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable to medicine. It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

"It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. *Patient must be notified in advance of the existence of this practice.*"

17. Investigations and Grievances: Several disciplinary investigations were conducted by members of the Membership and Discipline Committee. They functioned at times as an investigative resource of the Judicial Council and on other occasions as deputies of the Board of Medical Examiners.

A normal number of grievances was received by the Judicial Council and assigned to the appropriate county medical societies for investigation. Most of these were resolved at the local level but a half dozen or so were appealed to the Judicial Council. In these cases, the State Grievance Chairman conducted an independent investigation.

18. Formal Opinions of the Judicial Council: Your Council received, considered and ruled on a number of inquiries, most of which are of no general interest and therefore not reported in this report. In three cases, your Council promulgated formal opinions as follows:

OPINION 74-1: ACQUISITION OF A MEDICAL PRACTICE BY A COMMERCIAL CORPORATION

Physicians should not become involved with non-professional or commercial "for profit" corporations which seek to acquire the facilities and assets of physicians' practices on a basis which provides an incentive to maximize the profits of the commercial corporation while adversely affecting the cost and/or quality of medical care to the patient.

OPINION 74-2: RESTRICTION OF PRACTICE HOURS

A physician may limit his practice to specific office hours only and direct his patients needing care after those hours to hospital emergency rooms. However, a physician limiting his practice in this manner must make doubly certain that all of his patients are aware of this procedure, and he must have a definite arrangement with another physician or physicians and/or the hospital emergency room for the care of his patients during the hours he is unavailable.

OPINION 74-3: PHYSICIANS WRITING HEALTH COLUMNS

It is not improper for physicians, not in active private practice, to write health columns for lay readers. It is generally inadvisable for physicians in active practice to write for the lay public on medical matters. It is preferable for physicians to act as advisors to writers who commonly serve the several lay publications carrying such articles who are skilled in their ability to translate medical information to lay groups for which they are writing. However, physicians in active practice may author articles on medical subjects under a pseudonym rather than their actual name, provided that such columns or articles are written under the auspices of the author's county medical society. The author must abide by all rules and regulations promulgated by the local medical society.

Resolution 75-1
AMA Delegates' Report
Polk County Medical Association

Upon recommendation of the Reference Committee Resolution 75-1 was not adopted.

Resolution 75-2
Election of FMA Officers
Polk County Medical Association

The Reference Committee recommended adoption of a substitute resolution for Resolution 75-2, Election of FMA Officers.

Substitute Resolution 75-2 was adopted.

Substitute Resolution 75-2

Election of FMA Officers

RESOLVED, That the House of Delegates request the Speaker to consider holding the nomination of all officers as a single item of business at the second meeting of the House of Delegates at each Annual FMA Meeting, and that he consider the election of all officers to be held as the first item of business at the third meeting of the House of Delegates (by secret ballot) and that the proceedings of the House be continued as the ballots are tabulated and those proceedings be halted at appropriate times to announce the election results or to provide opportunity for run-off elections.

Resolution 75-4
Osteopaths—FMA Membership
Lee County Medical Society

The Reference Committee recommended that Resolution 75-4 not be adopted.

The Reference Committee's recommendation did not pass.

A motion was made and seconded from the floor to adopt Resolution 75-4.

A standing vote of 138-73 adopted the resolution.

Resolution 75-4

Osteopaths—FMA Membership

RESOLVED, That the Florida Medical Association change its by-laws to allow county medical societies to accept as members osteopathic physicians who are deemed to be qualified and who have also satisfactorily completed an AMA approved internship and/or residency training program.

Resolution 75-27
Annual Meeting
Broward County Medical Association

Resolution 75-30
Legislative Session-House of Delegates
Hillsborough County Medical Association

The Reference Committee heard testimony on Resolutions 75-27 and 75-30 and considered the two resolutions together.

The Reference Committee recommended that inasmuch as the By-Laws assign the Board of Governors the responsibility for fixing the time of meetings, Resolutions 75-27 and 75-30 be referred to the Board of Governors for their consideration.

The recommendation was adopted.

Resolution 75-27

Annual Meeting

[NOT ADOPTED—REFERRED TO THE BOARD OF GOVERNORS FOR CONSIDERATION]

Whereas, The annual meeting of the House of Delegates to the Florida Medical Association is scheduled to be completed prior to the annual meeting of the American Medical Association; and after the winter rates of convention sites are reduced, and

Whereas, There is a definite need to communicate the principles and philosophies of this Association to the Florida Legislature prior to, or coincident with, its convening, it is

RESOLVED, That future meetings of the Florida Medical Association House of Delegates be scheduled prior to the convening of the Florida Legislature.

Resolution 75-30

Legislative Session—House of Delegates

[NOT ADOPTED—REFERRED TO THE BOARD OF GOVERNORS FOR CONSIDERATION]

Whereas, The Florida Medical Association increasingly is concerned with state and national legislation and governmental regulation of medicine, and

Whereas, The House of Delegates at its annual meeting, which is held during or following the regular session of the Florida Legislature, can contribute only minimal direction on the specific issues of legislation comprising the FMA legislative program to be submitted to the Florida Legislature at its next session; and

Whereas, The House of Delegates should be apprised of, provide input and lend the weight of its influence in the important area of legislation, be it

RESOLVED, That the House of Delegates hold an additional meeting at an appropriate time in the fall or early winter to consider national and state legislative issues and the legislative program of the Florida Medical Association.

Resolution 75-28
Single Board of Medical Examiners
Broward County Medical Association

The Reference Committee indicated that Resolution 75-28 would not serve the best interest of the Association at this time and recommended that Resolution 75-28 not be adopted.

Resolution 75-28 was not adopted.

A motion was made and seconded to reconsider Resolution 75-28.

The motion failed.

Resolution 75-29
Interns and Residents Dues
Hillsborough County Medical Association

Upon recommendation of the Reference Committee Resolution 75-29 was adopted.

Resolution 75-29

Interns and Residents Dues

RESOLVED, That the dues for medical interns and full time physicians in an approved residency or internship be reduced from $25 to $10 per year.

Resolution 75-38
Use of the Word "Physician"
Marion County Medical Society

Upon recommendation of the Reference Committee Resolution 75-38 was adopted.

Resolution 75-38

Use of the Word "Physician"

RESOLVED, That the House of Delegates of the FMA encourage proper legislation by the State of Florida to restrict the use of the word physician to those duly and properly privileged to use the word physician and to prevent its use by those not so qualified.

Dr. Fletcher: "Your Chairman wishes to thank the members of this committee, Doctors Jack Q. Cleveland; Joseph D. Hendrix; Richard B. Moore; Joseph H. Fitzgerald; Samuel M. Day and the members of the FMA who came to speak before the committee."

"The committee also wishes to thank Mrs. Carolyn Miller, our recording secretary, for her skill, patience and tireless labor to make this a successful report."

"Mr. Speaker, I move the adoption of the report of Reference Committee III as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. III."

Dr. Murray, the Speaker, made the presentations of the Certificate of Appreciation to Dr. Clyde M. Collins of Jacksonville, and Dr. Curtis W. Cannon of West Palm Beach.

CERTIFICATE OF APPRECIATION

WHEREAS, Clyde Mabry Collins, M.D., of Jacksonville, Florida, has given unselfishly of his time and effort in the service of the Florida Medical Association and its scientific journal; and

WHEREAS, A native of Atlanta, Georgia, Dr. Collins received his A.B. degree at Emory University in 1937, and his Doctor of Medicine degree at the Medical College of Georgia in 1942; and

WHEREAS, After completing residency training at the old Duval Medical Center in Jacksonville in 1953, Dr. Collins has spent his entire professional life in that city; and

WHEREAS, Dr. Collins, a general surgeon, is a Diplomate of the American Board of Surgery; a Fellow of the American College of Surgeons; and a Past President of the Florida Association of General Surgeons; and

WHEREAS, This soft-spoken, even-tempered gentleman served during World War II as a military medical officer and continues to serve his country through the Florida National Guard; and

WHEREAS, Dr. Collins has contributed to the Duval County Medical Society as its President and as Editor of its *Bulletin;* and

WHEREAS, This distinguished surgeon was first appointed Editor of *The Journal of the Florida Medical Association* in 1970, a position he was to hold for five consecutive years; and

WHEREAS, Dr. Collins has given *The Journal* his complete dedication and undivided attention, standing behind it squarely in both good times and lean; and

WHEREAS, Editorials and other commentary from the pen of the Editor these last five years have added a distinctive flavor to *The Journal;* and

WHEREAS, As Editor, Dr. Collins presided over the publication of the January, 1974 Centennial Issue of *The Journal*, a work honored and acclaimed as a collector's item by the Florida Magazine Association; and

WHEREAS, Dr. Collins has left an indelible mark on *The Journal* and his influence no doubt will be felt for years to come; therefore be it

RESOLVED, That the Certificate of Appreciation, established in 1961 for the purpose of acknowledging exceptionally meritorious service, be presented to Clyde M. Collins, M.D., in recognition of his many years of devoted service to the Florida Medical Association, particularly as Editor of *The Journal.*

President Thad Moseley, M.D. presents FMA's Certificate of Appreciation to Clyde M. Collins, M.D., marking the conclusion of Dr. Collins' five-year tenure as Editor of The Journal.

Curtis W. Cannon, M.D., West Palm Beach (left), receives FMA's Certificate of Appreciation from President Thad Moseley, M.D.

CERTIFICATE OF APPRECIATION

WHEREAS, Curtis W. Cannon, M.D., Orlando-born obstetrician-gynecologist practicing at West Palm Beach, Florida, has rendered valuable services to his profession and his community; and

WHEREAS, Dr. Cannon earned Bachelor of Science and Master of Science degrees at Florida State University and his Doctor of Medicine degree at the University of Miami School of Medicine; and

WHEREAS, He took internship and specialty training at the former Duval Medical Center in Jacksonville prior to establishing his private practice at West Palm Beach in 1960; and

WHEREAS, Dr. Cannon is a Fellow of the American College of Obstetrics and Gynecology; and

WHEREAS, As a member of the Palm Beach County Medical Society, he has served as President and has worked to bring about better relations between his county society and the news media and between his county society and the local legislative delegation; and

WHEREAS, The Palm Beach County Health Department has benefited for many years from Dr. Cannon's work as a consultant and Tumor Clinic physician; and

WHEREAS, Always active in community affairs, Dr. Cannon has served for two years as President of the Palm Beach County Unit, American Cancer Society; and once served as President of his Kiwanis Club; and

WHEREAS, He has served for five years as Chief of Obstetrics of Good Samaritan Hospital at West Palm Beach; and

WHEREAS, Dr. Cannon has served the Florida Medical Association as Chairman of the Committee on Health Insurance, and as a member of the Subcommittee on Medical Foundations, the Council on Medical Economics and the Committee on Membership and Discipline; therefore be it

RESOLVED, That the Certificate of Appreciation, first awarded in 1961 for the purpose of acknowledging exceptionally meritorious service, be presented to Curtis W. Cannon, M.D., in recognition of his many years of devoted service to the Palm Beach County Medical Society and to the Florida Medical Association.

Dr. Collins accepted the award and expressed his gratitude. He stated that one of the satisfactions in life is getting involved in something worthwhile. He expressed his thanks to the many fine people with whom he had worked for the past five years as Editor of the Journal.

Dr. Cannon also expressed his appreciation for the award and commented that it came as a total surprise to him.

The rostrum was turned over to the Vice Speaker, Dr. Kahn, who requested the members of Reference Committee No. IV to come forward to present their report.

Sen. Henderson proudly displays his award.

Sen. Warren S. Henderson, Venice (left) receives an award from the Florida Pediatric Society and Florida Chapter, American Academy of Pediatrics for his work in the passage of the nation's first neonatal insurance bill which mandates by law that the newborn is covered by insurance from the first day of life. Presenting the award was Dr. Henry G. Morton, Sarasota, long time personal friend of Senator Henderson, pediatrician to the Henderson children and a Past President of the Florida Pediatric Society.

Dr. James M. San, Tampa, President of the Florida Pediatric Society congratulates Sen. Henderson on his achievement.

Report of Reference Committee No. IV
Legislation and Miscellaneous

Dr. Sanford A. Mullen, Chairman of Reference Committee No. IV, presented the report of his Reference Committee.

Council on Legislation and Regulations

The Reference Committee was informed about the recently passed federal law "Health Planning and Resources Development Act of 1974" (PL93-641). The Committee believes that the impact of this law on the practice of medicine will be of major significance. The Reference Committee recommended that the "Health Planning Resources Development Act of 1974" be given careful consideration by the Board of Governors and that the Council on Legislation and Regulations develop a plan of action for the Florida Medical Association to deal with this law.

The recommendation was adopted.

Upon recommendation of the Reference Committee the Report of the Council on Legislation and Regulations was adopted.

Council on Legislation and Regulations

JAMES B. PERRY, *Chairman*

Most of the work of the Council on Legislation and Regulations is accomplished through the activities of its two committees: Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as the individual reports of the two major committees.

Committee on National Legislation—This committee consists of the key contact physicians for each member of the Florida Delegation in the U. S. Senate and the U. S. House of Representatives.

Members of this committee have kept in close touch with their assigned Senators and Congressmen on national legislation matters of interest to FMA and the American Medical Association.

A highlight of the committee's activities was the annual congressional visitation which was held in March in conjunction with the Annual AMA-AMPAC Public Affairs Workshop in Washington, D.C.

This next year will be a very crucial one for physicians in Florida, and throughout the nation, because of the likelihood of congressional action on development of a program for national health insurance. In order to have the maximum resources of the Association available for this effort, particular emphasis will be placed on increased communication with local county medical societies during the coming year. It is anticipated that not only will the written communications be increased but, that with additional staff available, the Association offices can maintain close liaison with local county medical societies and key contact physicians.

The annual AMA-AMPAC Public Affairs Workshop has been called off for 1975 and the committee is in the process of developing a more personalized individual visit system between the key contacts and the congressmen in Washington. It is anticipated that by these individual visits, the key contact physicians will have a better opportunity to keep the congressmen informed of details of Association concerns.

While Medicredit, which is sponsored by the American Medical Association, will undoubtedly once again have the largest number of sponsors of any of the national health insurance programs in Congress, the committee does

Reference Committee IV considered Legislation and Miscellaneous. Left to right: Sanford A. Mullen, M.D., Jacksonville, Chairman; Recorder Mary Kay Samorisky; Thomas E. McKell, M.D., Tampa; Jerome Benson, M.D., Miami Beach; G. Brock Magruder, M.D., Orlando; and George A. Gant, M.D., Kissimmee.

not feel that any specific plans as introduced will pass this session of Congress. In view of this, emphasis will be made to educate congressmen about certain basic principles that must be included in any plan passed, rather than concentrating all efforts on trying to pass a specific bill.

Committee on State Legislation—The Committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized medical specialty groups. Four formal meetings of the committee have been held along with many informal conferences among committee members as items of an urgency nature arose. The committee is particularly pleased with the results of the Legislative Seminar, which was held as part of the annual FMA Leadership Conference in Orlando on January 26, 1975.

Consistent with the policies developed by the FMA House of Delegates, the committee has worked closely with the Board of Governors in developing a legislative program for the 1975 Session of the Florida Legislature.

The recently enacted dues increase has enabled the Association to add an additional staff person to the Capital Office which has measurably increased the capacity to follow the seemingly endless legislative proposals affecting physicians in Florida. With the expanded staff, it is felt that much closer day-to-day communication can be maintained with county medical societies on legislative activities, and key contact physicians can be more thoroughly informed of programs of FMA legislative objectives. The major new program of the committee for the coming year will be to get county medical society executives more directly involved in the legislative process by asking their county societies to send them to Tallahassee for a period of time while the Legislature is in session in order to make direct contact with members of their legislative delegation and coordinate activities of their key contact physicians in carrying out the Association's priority legislative objectives.

The following items summarize the committee's activities:

1. Capital Office—The Capital Office has continued to function under the supervision of Mr. Donald S. Fraser, Jr., Director of the Public Affairs Department of the FMA. The recent addition of George Palmer, Jr., as Manager of the Capital Office has materially increased the capacities of the Association to maintain closer coordination with county medical societies. In addition, the primary emphasis is being placed on using the resources of the Capital Office to provide better services and coordination for the various medical specialty groups.

2. The Capitol Dispensary—The committee has continued to place major emphasis on working with the Capitol Dispensary, which has proved to be most important in meeting the medical needs of legislators and their staffs. Edward G. Haskell Jr., M.D., who has served long and able as the physician in charge of the Capitol Dispensary on a day-to-day basis, has resigned and was replaced by George H. Evans, M.D., practicing urologist in Tallahassee. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary with the "Doctor of the Day" program.

3. Key Contact Physicians—The committee on State Legislation has continued to emphasize the need to develop a good key contact physician program in each county medical society in the state. A program has been undertaken to work with each county medical society in reviewing their assigned key contact physicians to make sure that the best possible physician is assigned this critical task.

4. Publications—The Legislative Bulletin was published every week during the legislative session and periodically between sessions. The Bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities.

5. 1974 Legislative Accomplishments—During the 1974 legislative session, there were 306 legislative proposals that required action by the state legislative committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

—Legislation requiring professional liability insurers of doctors of medicine and osteopathy to report annually to the Department of Insurance any medical malpractice claims.
—The enactment of statewide school health services plan.
—Defeat of legislation requiring the appointment of a layman to the State Board of Medical Examiners.
—Defeat of so-called "truth in sickness" legislation which among other things required physicians to make public disclosure of interest in or business transactions with hospitals, nursing homes, health maintenance organizations, pharmacies or clinical laboratories.
—Defeat of cost containment act which would have set up a state system for regulation of hospital and nursing home fees.
—Passage of legislation establishing family practice residency program.
—Defeat of bill to create independent nurse practitioners with authority for performing certain medical acts without supervision of a physician.
—Legislation to create an independent school of osteopathy.
—Passage of legislation granting judges discretion to exempt physicians from jury duty.
—Defeat of bill establishing drug formulary and allowing unrestricted substitution by pharmacists.
—Defeat of legislation which would establish mandatory coverage for chiropractors in all health insurance policies in Florida. (A bill relating to the subject passed but called for the coverage only if the request is made by an individual to the company.)
—Improved funding for Medicaid program, particularly with regard to flexibility for out-patient services.

6. Major Legislative Objectives for 1975 Session—The major legislative objectives for the 1975 Session of the Florida Legislature as established by the FMA House of Delegates and the FMA Board of Governors were:

—Maximum utilization of Association resources to bring about relief in the professional liability insurance crisis. Initial bills filed in this area by the Association were related to:
  a. Informed Consent
  b. Statute of Frauds
  c. Statute of Limitations
  d. Ad Damnum Clause
  e. Res Ipsa Loquitur
  f. Contingency Fees
—Establishment of a separate Department of Health Services.
—Opposition to establishment of a rate commission for hospital and nursing home rates and any other general legislation which attempts to create specific utility-type regulations for health care.
—Opposition to establishment of a school of osteopathy.
—Flouridation of public water supplies.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA Legislative program made during the 1975 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA annual meeting.

Supplemental Report
Council on Legislation and Regulations

The Reference Committee recommended continuing Florida Medical Association approval of HB 1266, "Statute of Frauds."

The recommendation was adopted.

The Reference Committee recommended that the bill, "Limitation of Liability: Patients Compensation" (HB 1267), leave to the individual physician the option to determine whether or not he should carry professional liability insurance.

A motion was made from the floor to add to the recommendation, "This determination shall not depend on the physician's demonstration of financial responsibility."

The motion was seconded and carried.

The motion was made and seconded from the floor to amend the amended recommendation by adding:

"1. The Florida Medical Association commends the legislature for the legislative relief known as the Omnibus Bill and considers it a good beginning towards solving the professional liability problem;

2. However, the FMA believes that its present form is inadequate as a solution to the professional liability problem so adversely affecting the health and welfare of the citizens of the State of Florida. Therefore, the Florida Medical Association strongly urges the Florida Legislature to immediately develop further legislation to include a specified limitation of damages without utilizing an unlimited fund and to pass legislation limiting and regulating the contingency fee."

The motion carried.

The recommendation of the Reference Committee was adopted as amended.

The Reference Committee recommended continuing approval by the Florida Medical Association of a reasonable and practical bill on Informed Consent (HB 1268).

The recommendation was adopted.

Upon recommendation of the Reference Committee the Administrative Board Bill (HB 1269) was approved.

The Reference Committee recommended continuing support of the bill on Statute of Limitations (HB 1270).

The recommendation was adopted.

The Reference Committee advised the House that the name of HB 1271, "Mediation Panel," has been changed to "Mandatory Arbitration Panel."

The Reference Committee recommended continuing approval of a Mandatory Arbitration Panel bill (HB 1271).

The recommendation was adopted.

The Reference Committee recommended support of a bill to establish a Joint Underwriting Association (HB 1272) provided that it is only used as a last resort and that it is in effect only on a temporary basis of two or three years.

The recommendation was adopted.

The Reference Committee recommended that every effort be made to preserve direct line authority by a doctor of medicine for all programs of health services throughout the state.

Upon recommendation of the Reference Committee the Supplemental Report of the Council on Legislation and Regulations was adopted as amended.

Supplemental Report Council on Legislation and Regulations

This is to update the report of the Council on Legislation and Public Agencies printed in the Delegates' Hand book. This report reflects the status of legislation as of April 21, 1975.

LEGISLATIVE STATUS OF FMA'S 1975 LEGISLATIVE PROGRAM

1. Legislation to Relieve the Professional Liability Insurance Crisis

As of the date of this report, the House of Representatives has passed a comprehensive package of professional liability insurance legislation which will be acted upon at the April 23, 1975 meeting of the Senate Commerce Committee. The bills in this package are:

HB1266—Statute of Frauds
HB1267—Limitation of Liability: Patients Compensation Fund for Excess Liability
HB1268—Informed Consent
HB1269—Administrative Board
HB1270—Statute of Limitations
HB1271—Mediation Panel
HB1272—JUA

Efforts are currently being made to develop a limitation on the amount of damages that can be paid out.

2. Establishment of a Separate Department of Health Services (HB523).

Legislation to establish a separate Department of Health Services has not yet received a hearing. The Florida Senate has already passed legislation (Senate Bill 165) which establishes a regional system for administration of all HRS programs with no major visability for health programs at the state level. The House version of this legislation, HB773, is currently being debated by the House Appropriations Committee.

3. Opposition to Establishment of a Rate Commission for Hospital and Nursing Home Rates (Senate Bill 173).

The Senate bill is on the Senate calendar and it is anticipated that a similar bill will soon be debated before the House Health and Rehabilitative Services Committee.

4. Opposition to Establishment of a School of Osteopathy (HB1390).

No hearings have been held on this bill as of this date.

5. Opposition to Fifth Pathway for Graduates of Foreign Medical Schools (Senate Bill 414, HB435).

No hearings have been held on the House bill or the Senate bill as of this date.

6. Legislation to Place Consumers on the State Board of Medical Examiners (Senate Bill 362).

This bill would place two consumers and three medical school faculty members on the State Board of Medical Examiners in place of five private physicians.

OTHER LATE DEVELOPING LEGISLATIVE ACTIVITIES

The Council would ask for permission to introduce at the reference committee any item of major significance that might have arisen in the Legislature between April 21, 1975 and the time of the FMA meeting.

Report of Board of Governors Board Action No. 18

Upon recommendation of the Reference Committee Board Action No. 18 was adopted. (See Report of Board of Governors, Page 52)

AMA President Malcolm C. Todd, M.D., Long Beach, Calif. (center), paid a surprise visit to the FMA convention. Here he chats with a couple of old friends, AMA Delegate Francis C. Coleman, M.D., Tampa (left), and AMA Trustee Jere W. Annis, M.D., Lakeland.

Council on Legislation and Regulations

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "Council on Legislation and Regulations" was adopted.

Resolution 75-11 Certification of Disability for Homestead Exemption Volusia County Medical Society

The Reference Committee advised that testimony was heard to the effect that such a change in the law, while providing some convenience to individual physicians, would have a very real danger of putting a physician in an untenable position because of undue pressures for him to establish the existence of disability. The Committee believes that disability should be established only with proper safeguards to avoid abuse.

The Reference Committee recommended that Resolution 75-11 not be adopted.

The recommendation of the Reference Committee was adopted.

Resolution 75-14 Physician Attendance in Legislature Pinellas County Medical Society

Upon recommendation of the Reference Committee Resolution 75-14 was adopted.

Resolution 75-14

Physician Attendance in Legislature

RESOLVED, That the Florida Medical Association in cooperation with the component societies encourage and coordinate a continuing program of physician attendance at the Legislature now in session.

Resolution 75-17 The Rights of Privacy Duval County Medical Society

The Reference Committee heard testimony supporting this resolution and, with the approval of the Duval County Medical Society representatives, amended the "RESOLVED" portion.

Upon recommendation of the Reference Committee Resolution 75-17 as amended was adopted.

Resolution 75-17

The Rights of Privacy

RESOLVED, that the Florida Medical Association request the Florida Legislature to pass necessary legislation to prevent the loss of privacy of medical records resulting from the Public Records Law.

Dr. Mullen: "Your Chairman wishes to thank the members of this Reference Committee, Drs. George A. Gant, Thomas E. McKell, G. Brock Magruder and Jerome Benson, and the members who came to speak before the Committee. Without the efforts, assistance and cooperation of all the above, this report would not have been possible. This Reference Committee especially wishes to thank Mrs. Mary Kay Samorisky, our Secretary, for her able assistance and cooperation in the speedy preparation of this report."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. IV as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. IV.

The President, Dr. Moseley, assumed the Chair to advise the House that Dr. James B. Perry had been appointed as Chairman of the Council on Legislation and Regulations in January so that continuity could be maintained instead of appointing a new Chairman in the middle of the legislative session. Dr. Sanford Mullen, who was Chairman of the Council on Legislation and Regulations for many years, was commended by the House for the excellent work that he had done for the Association and the physicians of Florida.

Dr. Mullen expressed his appreciation for the tribute.

Dr. David C. Lane of the Florida State Senate and member of the FMA House of Delegates, brought the House up to date on the issues being considered by the Legislature. He advised that the House Commerce Committee considered the Omnibus Bill last Friday afternoon and passed it unanimously. He pointed out that the House of Delegates meetings should be held before the Legislature convenes to allow time for the actions of the House pertaining to legislation to be transmitted to the Legislature. Dr. Lane discussed the bill pertaining to single doctor certification as opposed to two doctors certifying on total disability and the contingency fee bill. Dr. Lane expressed his appreciation to the FMA for their support.

Report of Reference Committee No. V

Medical Economics

The Speaker, Dr. Murray, assumed the Chair and called for the report of Reference Committee No. V, Medical Economics.

Dr. Paul C. Harding, Chairman, and members of the Reference Committee came forward to present the report of Reference Committee No. V.

Council on Medical Economics

Upon recommendation of the Reference Committee, the Report of Council on Medical Economics was published and filed.

Council on Medical Economics

JAMES F. RICHARDS JR., *Chairman*

The Council on Medical Economics held four meetings this year, two of which, September 24, 1974, and January 3, 1975, were held prior to the Board of Governors Meetings. The Council considered recommendations of its committees, the Committee on Relative Value Studies and Fee Schedules, Chairman Charles Donegan, M.D., St. Petersburg, and the Committee on Health Insurance, Chairman James F. Richards Jr., M.D., Orlando, and Co-chairman Curtis W. Cannon, M.D., West Palm Beach. Most of the recommendations were endorsed by the Council.

The Council met on two other occasions. On November 20, 1974 Drs. Donegan and Richards, along with FMA Staff, met with and testified before, the Department of Health and Rehabilitative Services Task Force considering the Department's Fee Schedule. The Council testified and pleaded on behalf of a more realistic Fee Schedule. It was pointed out that the present Fee Schedule is well below Medicare, which is based on 75th Percentile and far below Usual and Customary, or 90th Percentile. These figures were given to the task force for comparison. The Fee Schedule has not been revised since 1972. The HRS Committee was in full sympathy and agreement that the Fee Schedule should be revised and pointed out the difficulties anticipated in the current budget year because of reduced state income.

The fourth meeting occurred on January 24, 1975. During the afternoon the Chairman met with the Florida Hospital Association to discuss their attitude toward a peer review mechanism for the private sector. In the evening, a combined meeting of the Council on Medical Economics and Council on Medical Systems, Chairman Dr. James Borland, Jacksonville, and the entire Committee on Health Insurance was held. The major discussion concerned the parallel responsibilities of these two councils, that of Medical Economics, involving peer review in the private sector, and that of Medical Systems involving peer review in Medicaid and other government related areas. The Board of Governors, at its October meeting designated the Council on Medical Systems as the Steering Committee for statewide Professional Review Organization planning and activities and appointed the Chairman of the Council Medical Economics as a member of that Steering Committee. The combined meeting was held for the purpose of relating to the Council on Medical Systems or Steering Committee, the activities of the Council on Medical Economics as they pertain to peer review.

The Health Insurance Committee met four times, August 24, 1974, November 24, 1974, both in Orlando, December 20, 1974 in Tampa and January 24, 1975 in Orlando. At the August meeting the Committee on Health Insurance expressed the desire to invite input from Blue Shield; and felt that it should be able to consult Blue Shield and other health insurance carriers on problems when necessary. It was recommended that it be communicated to the membership of the FMA that the Committee on Health Insurance is concerned with any problems involving Blue Shield and other third party carriers and that these problems should be directed to the Committee. This was done in the January 24, 1975 issue of the "Briefs." It was further recommended that the Com-

Reference Committee V considered Medical Economics. Left to right: William W. Thompson, M.D., Fort Walton Beach; Donald G. Nikolaus, M.D., Dunedin; Recorder Diane Dickerson; Paul C. Harding, M.D., Orlando, Chairman; James R. Jude, M.D., Miami; and Karl R. Rolls, M.D., Sarasota.

mittee on Health Insurance felt reservation and apprehension that information gained through peer review for the private insurance sector could be indiscriminately published to the detriment of individual physicians and recommended that this information be prohibited from use to prosecute physicians. It was further felt by the Committee on Health Insurance that staff, plus a physician, should make an on site review and inspection of the program for peer review of the private health insurance business of the Georgia Foundation for Medical Care.

Dialogue was established between the Health Insurance Association of America, representing 90% of the health insurance industry in the State of Florida. Further development of a peer review mechanism for the private health insurance industry in the state of Florida. Further dialogue and/or negotiations will subsequently be carried on by the Steering Committee composed of the Council on Medical Systems as described above with the Council on Medical Economics and Health Insurance Committee being an advisory group.

The Committee on Relative Value Studies and Fee Schedules met six times in Tampa, Florida, two of those being full weekend sessions. The dates were June 1, 1974, August 17, 1974, October 19, 1974, November 9th and 10th, 1974, November 23, 1974, February 15th, and March 15th and 16th, 1975. This Committee is grateful for the help of William M. Howard, Ph.D., Consultant, and Mrs. Elinor Bowman, M.S., Statistician. The Committee has undertaken its charge of revising the 1971 Florida Relative Value Study. The Committee and the Council on Medical Economics recommended the use of Coding and Nomenclature of the California Relative Value Study in the revision of the 1971 Florida Relative Value Study. This has been approved by the Board of Governors.

Many hours were spent developing the questionnaires to be used in revising the RVS. The Committee conducted a pilot survey in Sarasota County to perfect the questionnaire and survey procedures before surveying the entire Florida Medical Association membership. These questionnaires were circulated to the Council on Specialty Medicine asking their advice and recommendations regarding inclusion or omission of items, and any other suggestions or observations. It is anticipated that there will be approximately sixteen hundred (1,600) additional descriptors in the 1975 Florida Relative Value Study. The Sarasota survey should be completed by late February or early March and it is anticipated the Relative Value Study itself may be ready to print by summer 1975.

The Council will petition for a hearing at an early date before the Workmen's Compensation Commission. Armed with statistics from Blue Shield, Medicare and the Sarasota survey, testimony will be given to demonstrate that the prevailing fees are in excess of those permitted under the current Workmen's Compensation Medical and Surgical Fee Schedule. In addition, it will be requested that the eight items, which are dollar figures in the 1972 Workmen's Compensation Fee Schedule, specifically Office Visits, Hospital Visits, Injections and Physicial Therapy be changed to Relative Value figures. It will be argued that, as in the new Florida Relative Value Study Manual, there should be acknowledgment of several levels of examination regarding New Patient, Established Patient, Hospital Care and Consultation. We will also ask for five digit coding, as will appear in the most recent Florida Relative Value Study.

The Council and its Committees also discussed problems posed by physicians and insurance companies including a fee differential for eye examinations performed by Ophthalmologists and Optometrists. The Council also recommended the adoption of new definitions for cosmetic surgery and reconstructive surgery. These were approved by the Board at its October Meeting.

Both of the Committees within this Council deserve a great deal of thanks and credit for the many long hours and conscientious deliberations on behalf of the Florida Medical Association.

Supplemental Report
Council on Medical Economics

Upon recommendation of the Reference Committee the Supplemental Report of the Council on Medical Economics was published and filed.

Supplemental Report
Council on Medical Economics

In as much as the latest Workmen's Compensation Medical and Surgical Fee Schedule for the State of Florida became effective on July 20, 1972, work was done during the past year to prepare facts to substantiate a request to the Bureau of Workmen's Compensation for a substantial change in the Fee Schedule. It was impractical and ill advised to make such a preparation during the Price Freeze (with which we are all familiar), but as soon as the freeze was lifted, work commenced to prepare and document evidence for the request.

In order to present evidence that fees have risen, we must have statistically valid material. Toward that end, we have utilized the F.M.A. pilot survey on fees conducted by the Committee on Relative Value Studies and Fee Schedules in Sarasota County, in early 1975, as a valid base upon which to testify. The statistical analysis of this survey was completed in March 1975 by William M. Howard, Ph.D., Actuarial Consultant to the Committee. In addition to this material, we have a wealth of information accumulated by the Medicare experience in the State of Florida and, although, Medicare payments are at the 75th percentile, they give us the base from which to testify regarding the prevailing, or 90th percentile, in the various parts of the state.

Our recommendations are that the fee level should be equal to that which prevails in a community in accordance with the Workmen's Compensation law. The Bureau recognizes the entire state as a single community and ignores the fact that various parts of the state have higher and lower costs of practicing medicine. The Fee Schedule should be based on current medical terminology instead of obsolete terminology and we have recommended the use of the most current Florida Relative Value Study in print. We also recommended that the medical and surgical fee schedule be revised annually.

One of the most blatant areas of inequity is in first office visit, subsequent office visit, first hospital visit and subsequent hospital visit. In these four areas we have requested that the Bureau recognize various levels of complication of visit, for instance, brief, limited, intermediate and comprehensive, as is recognized in all other Relative Value Studies in the nation.

With the help of our FMA Attorney, Mr. Del Gibbs, we have petitioned for a hearing, which we hope will be held during the month of April, 1975.

Council on Medical Systems

Upon recommendation of the Reference Committee the Report of Council on Medical Systems was published and filed.

Council on Medical Systems

JAMES L. BORLAND JR., *Chairman*

Having been created in May, 1974, the Council on Medical Systems is a new entity which encompasses new responsibilities as well as functions formerly assigned to committees of two other councils and the Board of Governors. The Council's initial activity was to clarify

and delineate its scope of responsibility which extends basically to the performance of medical peer review and other quality assurance activities, the evaluation and monitoring of federal and state programs affecting the practice of medicine, the development of foundations for medical care, and the relationship between physicians and hospitals. The Council's four committees are Foundations for Medical Care, Government Programs, Hospitals and Extended Care Facilities, and PMUR-PRO. As of the date of this report (February 18, 1975), the Council has held two formal meetings and has met jointly with the Council on Medical Economics in another meeting.

The primary efforts of the Council during the period of this report were devoted to the study and development of steps leading to the establishment of a state professional review organization (PRO) capable of performing medical peer review and other professional quality assurance services for governmental programs and private insurance carriers. The Council was designated by the Board of Governors as steering committee for this activity. Also serving as a member of the steering committee is the chairman of the Council on Medical Economics. During the past several months, numerous meetings have been held between the Council chairman, the Association's officers and staff and representatives of the Florida Department of Health and Rehabilitative Services and various health data processing firms. The purpose of these meetings was to discuss the possibility and feasibility of the Florida Medical Foundation entering into an agreement with the state to provide medical peer review for the Florida Medicaid (Title XIX) program. This needed service would become the initial component of the state PRO. As of this writing, such an agreement appears imminent. Included in the agreement would be provision for one or more pilot projects in interested counties.

The following other major activities were carried out by the Council and or one of its committees during this reporting period:

—Continued to provide retrospective medical peer review for the Florida Medicare (Title XVIII) program, under an agreement between the Florida Medical Foundation, Blue Shield of Florida, and the Bureau of Health Insurance, Social Security Administration.

—Reviewed Escambia County efforts to develop a workable substitute for PSRO peer review and made appropriate recommendations to the Board of Governors.

—Recommended adequate compensation for the PMUR-PRO Committee in performing claims review for private insurance carriers.

—In conjunction with the Council on Medical Economics, considered the development of a program to furnish peer review for private insurance carriers desiring such services.

—Monitored a Duval County medical care project for Greyhound employees and established a mechanism for furnishing required outside professional review for the project.

—Evaluated a series of proposals for a Florida Medical Foundation—Florida Regional Medical Program grant project to provide education for physicians in peer review and quality assessment techniques and recommended approval of the final agreement which was executed in January.

—Studied medical care problems in extended care facilities and began development of appropriate recommendations.

—Approved and recommended adoption of revision of guidelines for formulation of hospital medical staff by-laws.

—Studied and evaluated the Florida Comprehensive Health Planning program and initiated development of recommendations for more adequate physician participation in "A" and "B" agencies.

—Evaluated and recommended FMA approval of the Professional Foundation for Health Care, Inc. of Hillsborough County.

—Reviewed proposed pilot medical peer review programs for Medicaid recipients in Duval County and Lake County.

—Attempted to remain abreast of national and state legislative and other governmental developments having impact on the practice of medicine.

If the broad yet intensive scope of the Council's activities in its first year of existence is an indicator, the future of the Council on Medical Systems will be a busy one.

Report of Board of Governors Board Action No. 3 FMIT Program-Psychiatric Benefits

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "FMIT Program-Psychiatric Benefits," Board Action #3, was published and filed.

(See Board of Governors Report, Page 51.)

Board Action No. 4 PSRO

Upon recommendation of the Reference Committee Board Action No. 4, PSRO, was published and filed.

(See Board of Governors Report, Page 52.)

Board Action No. 6 PMUR

Upon recommendation of the Reference Committee Board Action No. 6, PMUR, was published and filed.

(See Board of Governors Report, Page 52.)

Board Action No. 16 FMA Insurance Programs

Upon recommendation of the Reference Committee Board Action No. 16 was published and filed.

(See Board of Governors Report, Page 52.)

Board Action No. 17 Medicaid Program Length of Stay Criteria

Upon recommendation of the Reference Committee Board Action No. 17 was published and filed.

(See Board of Governors Report, Page 52.)

Board Action No. 19
Professional Liability Insurance

Upon recommendation of the Reference Committee Board Action No. 19 was published and filed.

(See Board of Governors Report, Page 53.)

Board Action No. 20
Blue Shield
Recommendation No. 3

Upon recommendation of the Reference Committee Board Action No. 20 and Recommendation No. 3 of the Board of Governors Report was adopted.

(See Board of Governors Report, Page 53.)

Committee on Health Insurance

Upon recommendation of the Reference Committee the portion of the Report of Board of Governors entitled, "Committee on Health Insurance" was published and filed.

(See Board of Governors Report, Page 55.)

Revision of 71 RVS

Upon recommendation of the Reference Committee the portion of the Board of Governors Report entitled, "Revision of the 71 RVS" was adopted.

(See Board of Governors Report, Page 55.)

Recommendation No. 9
Cosmetic and Reconstructive Surgery

The Reference Committee corrected the word "familiar" to "familial" in the second paragraph of the recommendation and recommended that the corrected recommendation be adopted.

Recommendation No. 9 was adopted.

(See Board of Governors Report, Page 55.)

Peer Review
of the Private Health Insurance Sector

Upon recommendation of the Reference Committee the Board Item entitled "Peer Review of the Private Health Insurance Sector" was published and filed.

(See Board of Governors Report, Page 55.)

Fee for Vision Analysis

Upon recommendation of the Reference Committee the Board Item entitled "Fee for Vision Analysis" was published and filed.

(See Board of Governors Report, Page 55.)

Workmen's Compensation Medical and Surgical Fee Schedule

Upon recommendation of the Reference Committee the Board Item entitled, "Workmen's Compensation Medical and Surgical Fee Schedule" was published and filed.

(See Board of Governors Report, Page 55.)

DHRS—Medical Fee Schedule

Upon recommendation of the Reference Committee, the Board Item entitled, "DHRS—Medical Fee Schedule," was published and filed.

(See Board of Governors Report, Page 55.)

PSRO

Upon recommendation of the Reference Committee the portion of the Board of Governors report entitled, "PSRO," was published and filed.

(See Board of Governors Report, Page 56.)

PRO

Upon recommendation of the Reference Committee the portion of the Board of Governors report entitled, "PRO" was published and filed.

(See Board of Governors Report, Page 56.)

FMF—(PRO) Peer Review—Medicaid

Upon recommendation of the Reference Committee the Board Item entitled, "FMF (PRO) Peer Review—Medicaid" was published and filed.

(See Board of Governors Report, Page 56.)

Quality of Care Assessment

Upon recommendation of the Reference Committee the Board Item entitled, "Quality of Care Assessment" was published and filed.

(See Board of Governors Report, Page 56.)

Hillsborough Foundation

Upon recommendation of the Reference Committee the Board Item entitled, "Hillsborough Foundation" was published and filed.

(See Board of Governors Report, Page 56.)

Resolution 75-5
Establishment of
Catastrophic Insurance Coverage
Duval County Medical Society

Upon recommendation of the Reference Committee Resolution 75-5 was adopted.

Resolution 75-5

Establishment of
Catastrophic Insurance Coverage

RESOLVED, That we of the Florida Medical Association strongly recommend to our Senators and Representatives in the Congress and to the AMA that they concentrate on the development and enactment of a bill to provide for catastrophic insurance coverage to fill an urgent unmet need and which coverage is fiscally attainable in the present strained state of the national economy and will not disturb the present private enterprise insurance coverage prevalent and serving us well at this time.

Resolution 75-6
Malpractice Insurance Surcharge
Putnam County Medical Society

Resolution 75-6 was not considered as no sponsor appeared before the Reference Committee.

Resolution 75-8
Blue Shield of Florida
Escambia County Medical Society

Upon recommendation of the Reference Committee, Resolution 75-8 was adopted.

Resolution 75-8

Blue Shield of Florida

RESOLVED, That the House of Delegates of the Florida Medical Association continues its pledge of support and expresses its confidence in the Board of Directors and Executive Staff of Blue Shield of Florida.

Resolution 75-10
Release of Medical Records to Insurance Carriers
Okaloosa County Medical Society

Upon recommendation of the Reference Committee Resolution 75-10 was referred to the Board of Governors for the purpose of indepth study and implementation of a program to protect the confidentiality of patient records.

Resolution 75-10

Release of Medical Records to Insurance Carriers

[Not Adopted—Referred to Board of Governors for indepth study and implementation of a program to protect the confidentiality of patient records.]

Whereas, The obligation of protecting the confidentiality of patient records is becoming increasingly difficult, and insurance companies, particularly Blue Cross, are, with increasing frequency, demanding entire hospital charts for review;

Whereas, Consents for release of this information are often not "informed consents," their having been obtained either on application for said insurance, as in the case of Blue Cross and other carriers, which may be months or years prior to the service, or in routine fashion, and in fine print on claim forms signed at hospital admission; and

Whereas, All hospitals accepting Medicare/Medicaid, and most contractual Blue Cross hospitals, now have approved Utilization Review Committees, be it

RESOLVED, That when an approved Utilization Review Committee exists, hospitals be allowed to furnish insurance carriers only inclusive dates and items of service, diagnoses, and the major procedures performed, unless the insured has read the entire records to be released and has then signed an "informed consent" for release of medical records; be it further

RESOLVED, That Blue Cross cease its present contractual arrangements with hospitals which require them to furnish any but the above information; be it further

RESOLVED, That any questions as to the appropriateness of care by a carrier be referred to the Utilization Review Committee at the carrier's expense; and that when an appeal of a local Utilization Review Committee decision is requested, it be referred to the appropriate local, regional or state medical society committee, again at the carrier's expense; and lastly, be it

RESOLVED, That the officers, board of governors, committees, members and employees of the Florida Medical Association be directed to use their offices to implement this Resolution through Blue Cross/Blue Shield and by legislative action as deemed necessary to protect the confidentiality of patient records.

Resolution 75-13
Liability Insurance—Contingency Fees
Pinellas County Medical Society

The Reference Committee recommended amending Resolution 75-13 by changing the first part of the first RESOLVED to read: RESOLVED, That the contingency fee be identified as one of the causes of the large tort settlements in professional liability suits."

The recommendation was adopted.

A motion was made from the floor to amend the amended Resolution 75-13 by adding, "RESOLVED, That the Florida Medical Association Board of Governors explore and pursue appropriate reform through the judicial as well as the legislative branch of Florida government."

The motion carried.

Resolution 75-13 was adopted as amended.

Resolution 75-13

Liability Insurance—Contingency Fees

RESOLVED, That the contingency fee be identified as one of the causes of the large tort settlements in professional liability suits; that the contingency fee along with the large settlements has resulted in the increased filing of claims causing our medical liability crisis, and be it further

RESOLVED, That we communicate this message to our Florida Medical Association membership and urge them to inform their patients and the citizens of Florida, and be it further

RESOLVED, That the Florida Medical Association Board of Governors explore and pursue appropriate reform through the judicial as well as the legislative branch of Florida government.

Resolution 75-18
Professional Liability Insurance
Dade County Medical Association

Resolution 75-18 was not considered as no sponsor appeared before the Reference Committee.

Resolution 75-9
Medicaids Length-of-Stay Controls
Escambia County Medical Society
Resolution 75-12
Medicare-Medicaid Certification Procedures
Volusia County Medical Society
Resolution 75-19
Utilization Review Regulations
Manatee County Medical Society
Resolution 75-21
Utilization Review Regulations
Brevard County Medical Society

The Reference Committee considered all the Resolutions listed above, together with the Board Item entitled, "FMF (PRO) Peer review—Medicaid," as they all relate to the same subject.

The Reference Committee noted that the AMA suit against HEW is attacking the very same regulations at the national level that HRS has instituted at the state level in similar regulations.

The Reference Committee recommended that FMA strongly support the AMA in its suit against the type of regulations referred to in these resolutions.

A motion was made from the floor to amend the recommendation of the Reference Committee by inserting after "these Resolutions":

". . . but if the AMA loses its suit, then the position of FMA will be reflected as the 'RESOLVED' portion of Resolution 75-21 with the change of 'non-compliance' to read as 'non-participation'."

The amendment to the recommendation failed.

The recommendation of the Reference Committee was adopted.

The Reference Committee recommended that until the litigation is settled, FMF continue its present program of Peer Review, and negotiate the best possible contract with HRS, subject to appropriate revision after the litigation is final.

The recommendation was adopted.

The Reference Committee recommended that Resolutions 75-9, 75-12, 75-19, and 75-21 be referred to the Board of Governors.

A motion was made from the floor to amend the recommendation by deleting Resolution 75-12 from the recommendation and voting on it as a separate issue.

The Chair ruled this motion out of order.

After an appeal of this ruling the House voted in favor of upholding the ruling of the Chair.

The recommendation of the Reference Committee that Resolutions 75-9, 75-12, 75-19, and 75-21 be referred to the Board of Governors was adopted.

Resolution 75-9

Medicaid Length-of-Stay Controls

[Not Adopted—Referred to the Board of Governors]

Whereas, The State of Florida Division of Family Services, Department of Health and Rehabilitative Services elects to impose length of stay controls on Medicaid patients effective February 1, 1975, and

Whereas, These controls are vague and ambiguous related to diagnosis and age, and

Whereas, These controls as stated are impossible to conform to in the everyday practice of medicine to maintain quality care, and

Whereas, These controls procedures rely on physician prophesy to obtain waivers of controls to lengthen stay in the hospital and further erode quality medical care, and

Whereas, Physicians continue to wish to provide quality medical care to Medicaid patients, therefore be it

RESOLVED, That the Escambia County Medical Society demand that these criteria be abolished and that the Division of Family Services recognize that the medical profession must set the criteria for patient care.

Resolution 75-12

Medicare-Medicaid Certification Procedures

[Not Adopted—Referred to the Board of Governors]

Whereas, Medical Staffs and hospitals are currently satisfactorily participating in Utilization Review and Medical Audit, and

Whereas, New HEW directives demand certification of Medicare and Medicaid admissions within one working day after admission, such certification being impossible to accomplish in this time limit, be it

RESOLVED, That the FMA and its members will not participate in any manner implementing new HEW certification procedures regarding Medicare and Medicaid patients.

Resolution 75-19

Utilization Review Regulations (P.L. 92-603)

[Not Adopted—Referred to the Board of Governors]

Whereas, The Manatee County Medical Society is a duly recognized affiliate organization of the Florida Medical Association; and

Whereas, The membership of the Manatee County Medical Society is dedicated to the furtherance of the quality of medical practice and the sanctity of the physician-patient relationship; and

Whereas, The Utilization Review Regulations as dictated in Section 237 (C) of Public Law 92-603 are contrary to and in aggravation of these basic philosophies of good medical practice; and

Whereas, In order to preserve the financial solvency of the hospitals in which they practice, physicians have been forced to ratify such Utilization Plans which flagrantly violate the individual's rights as a citizen and the physician's privilege to practice medicine; and

Whereas, The further perpetration of this authoritarian legislation will unquestionably serve to increase the costs of medical care to the patients and the public and to dictate the practice of medicine to the physician based on an abstract statistical exercise; now, therefore, be it

RESOLVED, That the Florida Medical Association rejects in its entirety the concept of Utilization Review as specified in the plan dictated by Section 237 (C) of Public Law 92-603 and requires its physician member organizations statewide to join in this resolution.

Resolution 75-21

Utilization Review Regulations (P.L. 92-603)

[Not Adopted—Referred to the Board of Governors]

RESOLVED, That the Florida Medical Association recommend to its members the philosophy of "non-compliance" in dealing with the provisions of Public Law 92-603 (Utilization Review section of the Medicare Law).

Resolution 75-23
Physicians Defense Trust
Brevard County Medical Society

The Reference Committee recommended that because of the legal implications, the large amounts of money, and the general overall complexity, and the enormity of such a program, the Resolution should be referred to the Board of Governors for study and consideration of its implementation as an additional approach or alternative to professional liability insurance.

The recommendation was adopted.

Resolution 75-23

Physicians Defense Trust

[Not Adopted—Referred to the Board of Governors]

RESOLVED, That the President and the Board of Governors of the Florida Medical Association consider an additional approach to the current malpractice insurance dilemma facing Florida's physicians—namely, the establishment of a "physicians defense trust" (somewhat along the lines contained in the text of Dr. David Rudloff's letter recently forwarded to the Executive Director of the F.M.A., copy of which has been inserted in the left-hand informational section of your packet); it must be emphasized clearly that such a proposal is for a "defense" trust only, with none of the trust funds available for settlement, even if malpractice, negligence or injury is proven.

Resolution 75-24
"Emergency-Care-Only" Days
Everett Shocket, M.D., Delegate, Dade Delegation

The Reference Committee recommended that Resolution 75-24 not be adopted.

A substitute resolution for Resolution 75-24 was presented from the floor.

The Substitute Resolution 75-24 was adopted.

A point of information brought out that the title, "Emergency-Care-Only" Days, had nothing to do with the Substitute Resolution.

Dr. Shocket retitled the Resolution, "Public Liability Insurance."

Substitute Resolution 75-24

Public Liability Insurance

RESOLVED, That the FMA respectfully endorses the current legislative package and appreciatively applauds its proponents in the Florida legislature, and be it further

RESOLVED, That the FMA looks forward to continuing legislative involvement and appropriate additional reforms as needed, and be it further

RESOLVED, That the FMA, through its Board of Governors remains prepared to mobilize as needed, all meaningful resources to ensure the continuity of health care delivery to Floridians, and to that end, to ensure appropriate liability insurance coverage to the physicians of Florida.

Resolution 75-25
Professional Liability Insurance Comprehensive Program
Duval County Medical Society

The Reference Committee corrected a typographical error in the last Resolved, changing the word cause to causes and recommended that the first "Resolved" be amended by changing the words "this critical problem" to read, "the critical professional liability insurance problem."

The recommendation was adopted.

Upon recommendation of the Reference Committee Resolution 75-25 was adopted as amended.

Resolution 75-25

Professional Liability Insurance Comprehensive Program

RESOLVED, That the Florida Medical Association initiate plans to employ expert professional assistance for the purpose of drafting the necessary laws to reduce the critical professional liability insurance problem for

Florida physicians and society in general, such professional help to be comprised of insurance, legal, legislative and other knowledgeable persons in a consultative role and, be it further

RESOLVED, That the Florida Medical Association be urged to seek legislation to correct the *basic* causes of this problem of society.

Resolution 75-33
F.M.I.T. Psychiatric Benefits
Pinellas County Medical Society

Upon recommendation of the Reference Committee Resolution 75-33 was adopted.

Resolution 75-33

F.M.I.T. Psychiatric Benefits

RESOLVED, That the FMA House of Delegates instruct the Board of Governors and the F.M.I.T. to re-establish benefits for psychiatric evaluation and treatment in the major medical policies offered to the FMA membership.

Resolution 75-37
Joint Commission on
Accreditation of Hospitals' Rules
Herbert E. Brooks, M.D., Delegate

Upon recommendation of the Reference Committee Resolution 75-37 was adopted.

Resolution 75-37

Joint Commission on
Accreditation of Hospitals' Rules

RESOLVED, That the Florida Medical Association urges the Joint Commission on Accreditation of Hospitals to assiduously address itself to the modification of its suggestions and regulations as applied to the small hospital; be it further

RESOLVED, That this resolution with the appropriate editorial changes be introduced at the AMA annual session in June, 1975, by the FMA Delegation to the AMA.

Dr. Harding: "Your Chairman wants all of you to know that this was a joint adventure shared equally among the members of this Committee, and I thank Doctors William Thompson, Donald Nikolaus, Karl Rolls, and James Jude for their cooperation and support. Reference Committee V was most fortunate to have the secretarial support of Mrs. Diane Dickerson whose expertise lead to prompt completion of this report."

"Mr. Speaker, I move the adoption of the Report of Reference Committee No. V as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee V."

Report of AMA Delegates Reference Committee

The Speaker, Dr. Murray, assumed the Chair and called for Dr. Francis T. Holland to present the Reference Committee Report of the AMA Delegates.

Dr. Holland's report was received as information.

Reference Committee Report AMA Delegates

FRANCIS T. HOLLAND, M.D., *Chairman*

The AMA Delegates Reference Committee met at 9 a.m. Friday in the Pan American Room. Also present were Dr. Jere Annis, AMA Trustee, and the alternate delegates from Florida. Although this has been one of the largest attendance we have had it was still very slim, which gives rise to the question as to whether this is productive or not. This committee reminded me of many years ago when the Florida officers went around to the various districts to meet with the grass roots. Many times when we got to the grass roots there were more officers of the Association attending than there were people from the grass roots. So, we wonder if this is productive at this time.

We wish to reiterate that all Florida Medical Association members are welcome to attend the AMA meeting and they can be heard at any Reference Committee. There will be either a delegate or alternate delegate from Florida assigned to attend the Reference Committee with whom you may consult if you wish. The duties of this delegate are to express the ideas of the Florida Medical Association and also to bring back the actions and discussions of the Reference Committee to the caucus of the Florida group before we vote.

For many years Dade County and many of the other large counties have sent some of their officers to attend meetings of the House of Delegates and I would urge all county societies that can possibly do so to send their representatives, especially when you have resolutions that are to go to the House of Delegates.

Your delegation meets in caucus at noon on the day the House convenes and at 7 a.m. each morning thereafter.

We often hear a doctor say, "I do not belong to the AMA because it does not reflect my feelings and I do not agree with all its programs." I wonder if he agrees with everything his county society or state society or specialty society says, or even what his wife does? We delegates do not always agree among ourselves, but we do, when we taken a position, act in a combined effort to support the Florida Medical Association programs that you direct us to. If there ever was a time for unity of all physicians it is now.

There was a time when specialty societies were going

off on their own reflecting their own position but now we notice they are mostly all returning to the AMA fold, realizing that all physicians must have a common organization and that we can speak with force for the physicians of America. Thank you.

Dr. Smith of Clay County requested the floor and recommended to the Board of Governors that when the contract expires with the Americana and Diplomat Hotels that consideration be given to holding the FMA Annual Meetings in north or central Florida. Dr. Murray advised that this is currently under investigation.

Elections

President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1975-1976.

Dr. Donald G. Nikolaus, Pinellas County, placed in nomination the name of Dr. Jack A. MaCris of St. Petersburg, Florida.

Dr. MaCris' nomination was seconded by Dr. Walter Jones of Dade County; Dr. Richard G. Connar of Hillsborough County; Dr. T. Byron Thames of Orange County; Dr. Robert E. Windom of Sarasota County; Dr. Emmet F. Ferguson Jr. of Duval County; and Dr. James T. Cook Jr. of Panhandle Medical Society.

Dr. Diran M. Seropian of Broward County placed in nomination the name of Dr. Ray E. Murphy Jr. of Pompano Beach, Florida.

Dr. Murphy's nomination was seconded by Dr. Franklin G. Norris of Orange County; Dr. Pedro J. Greer of Dade County; and Dr. John W. Glotfelty of Polk County.

Nominations were closed and upon secret written ballot Dr. MaCris was elected and requested to come to the podium.

Dr. Donald G. Nikolaus escorted Dr. MaCris to the podium.

Dr. MaCris: "Thank you very much. I just want to tell you that I do appreciate the privilege and honor to serve as President-Elect of the Florida Medical Association. I pledge to you my continued efforts on behalf of FMA and all of you as its members. Thank you."

Dr. Murphy congratulated Dr. MaCris and moved that a unanimous vote be recorded for Dr. MaCris.

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Harold L. Williamson of Hillsborough County placed in nomination the name of Dr. Irving M. Essrig of Tampa.

Dr. Essrig's nomination was seconded by Dr. Karl R. Rolls of Sarasota County; Dr. James F. Richards Jr. of Orange County; Dr. Henry M. Yonge of Escambia County; Dr. James L. Borland Jr. of Duval County; Dr. David S. Hubbell of Pinellas County; and Dr. Warren Lindau of Dade County.

Nominations were closed and a unanimous ballot was cast for Dr. Essrig.

Speaker of House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Edward W. Stoner of Orange County placed in nomination the name of Dr. Louis C. Murray of Orlando.

Dr. Murray's nomination was seconded by Dr. Jack Q. Cleveland of Dade County; Dr. Rowland E. Wood of Pinellas County; Dr. Harry W. Reinstine Jr. of Duval County; Dr. Francis T. Holland, AMA Delegate; Dr. Frank C. Cole-

Having just heard the announcement that Delegates had chosen him the new President-Elect, Jack A. MaCris, M.D., St. Petersburg, (left) is escorted to the dais by Donald G. Nikolaus, M.D., Dunedin.

man of Hillsborough County; and Dr. J. B. Perry of Broward County.

The nominations were closed and a unanimous ballot was cast for Dr. Murray.

Vice Speaker

Nominations for the office of Vice Speaker of the House were called for.

Dr. Philip B. Phillips of Escambia County nominated Dr. Charles J. Kahn of Pensacola.

Dr. Kahn's nomination was seconded by Dr. John C. Kruse of Duval County; Dr. Louis E. Cimino of Hillsborough County; and Dr. Calvin W. Martin of DeSoto-Hardee-Glades County.

Nominations were closed and a unanimous ballot was cast for Dr. Kahn.

Secretary

The floor was opened for nominations for the office of Secretary.

Dr. Emmet F. Ferguson Jr. of Duval County placed in nomination the name of Dr. James W. Walker of Jacksonville.

Dr. Walker's nomination was seconded by Dr. John H. Parker Jr. of Taylor County.

Nominations were closed and a unanimous ballot was cast for Dr. Walker.

Treasurer

The floor was opened for nominations for the office of Treasurer.

Dr. Robert E. Windom of Sarasota County placed in nomination the name of Dr. Richard S. Hodes of Tampa.

Dr. Hodes' nomination was seconded by Dr. Sanford A. Mullen of Duval County; Dr. J. G. Converse of Polk County; Dr. Larry Garrett of Lee County; and Dr. Frank C. Coleman of Hillsborough County.

Dr. Pedro Greer of Dade County placed in nomination the name of Dr. Julian H. Groff of North Miami Beach.

The nomination was seconded by Dr. J. B. Perry of Broward County.

The nominations were closed and upon secret written ballot Dr. Richard S. Hodes of Tampa was elected.

Dr. Groff requested that a unanimous ballot be recorded for Dr. Hodes.

AMA Delegates

The Vice Speaker called for nominations for election of an AMA Delegate to fill the unexpired term of Dr. Zellner. This term expires December 31, 1975.

A motion was made and seconded that this unexpired term be amalgamated with the two year term beginning January 1, 1976 and expiring December 31, 1977, and voted on at one time.

The motion carried.

Dr. Herbert E. Brooks of Panhandle Medical Society placed in nomination the name of Dr. James T. Cook Jr. of Marianna, to fill the vacancy in Seat No. 1.

Dr. Cook's nomination was seconded by Dr. Charles K. Donegan of Pinellas County and Dr. John Mason of Bay County.

The nominations were closed and a unanimous ballot was cast for Dr. Cook.

The Vice Speaker called for nominations for election of an AMA Delegate to fill Seat #4.

Dr. J. B. Perry of Broward County placed in nomination the name of Burns A. Dobbins, M.D.

Dr. Dobbins' nomination was seconded by Dr. R. J. Brennan of Broward County.

Dr. Robert Katims of Dade County moved to re-elect the entire slate of delegates and alternates for Seats #4 and #6 by acclamation for the entire two-year term.

The motion was seconded and carried.

The Vice Speaker called for nominations for Seat No. 7 which expires December 31, 1977.

Dr. T. John Kaminski of Brevard County placed in nomination the name of Dr. Joseph C. Von Thron of Cocoa Beach.

Dr. Von Thron's nomination was seconded by William F. Eckbert Jr. of Orange County; Dr. Richard W. Snodgrass of Volusia County; Dr. Calvin W. Martin of DeSoto-Hardee-Glades County; Dr. Karl R. Rolls, Sarasota County; and Dr. Robert Willner of Dade County.

Nominations were closed and a unanimous ballot was cast for Dr. Von Thron.

The Vice Speaker called for nominations to fill the alternate position for Seat #1 which was held by Dr. Cook.

The motion was made from the floor to consolidate the unexpired term and the new term for Alternate Seat No. 1.

The motion was seconded and carried.

Dr. Richard C. Dever of Dade County placed in nomination the name of Dr. Vincent P. Corso of Miami.

Dr. Corso's nomination was seconded by Dr. Thomas E. McKell of Hillsborough County; Dr. G. Brock Magruder of Orange County; and Dr. William M. Thompson of Okaloosa County.

The nominations were closed and a unanimous ballot was cast for Dr. Corso.

The Vice Speaker called for nominations for Alternate Delegate to Seat No. 7.

Dr. Dick Van Eldik of Palm Beach County placed in nomination the name of Dr. Curtis W. Cannon of West Palm Beach.

Dr. Cannon's nomination was seconded by Dr. William R. Eckbert Jr. of Orange County.

The nominations were closed and a unanimous ballot cast for Dr. Cannon.

The delegates are as follows:

Delegate	Dr. James T. Cook	Seat No. 1
Alternate	Dr. Vincent P. Corso	
Delegate	Dr. Burns A. Dobbins	Seat No. 4
Alternate	Dr. Eugene G. Peek	
Delegate	Dr. Rufus K. Broadaway	Seat No. 6
Alternate	Dr. T. Byron Thames	
Delegate	Dr. Joseph C. Von Thron	Seat No. 7
Alternate	Dr. Curtis W. Cannon	

The Speaker announced that the privilege of the floor would be given to Dr. Harold Parham.

Dr. Parham asked Mr. Eugene Nixon, Associate Executive Director for Florida Medical Association, to stand and be recognized for his service to the Association for the past twenty-years. Dr. Parham stated that Mr. Nixon had worked long and hard for the Association.

Dr. Parham also thanked the Executive Director, Mr. Donald C. Jones, and the entire staff for what he thinks has been a good job for this meeting.

Judicial Council

The Speaker referred the House to the report of the Board of Governors, in which it nominated Dr. William A. Thompson of Ft. Walton Beach for re-election for a five-year term expiring in 1980.

Motion carried to re-elect Dr. Thompson to membership on the Judicial Council.

The Board nominated Dr. William M. Straight for election from District D to fill the unexpired term of Dr. Zivitz, and this term will expire in 1977.

Motion carried to elect Dr. Straight to membership on the Judicial Council.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and asked for additional nominations from the floor.

There were no additional nominations.

Motion carried to elect the nominees submitted by the Board of Governors to the Committee on Membership and Discipline (See Report of Board of Governors, Page 50).

Installation of President

Dr. Moseley: "I face this moment with mixed emotions, all of which are relief in its many facets. I face it with confidence for the future because you have as your President-Elect a man who is knowledgeable, who has worked this year,

Vernon B. Astler, M.D. (left) accepts the President's gavel from retiring President Thad Moseley, M.D. at third session of House of Delegates.

New President Vernon B. Astler, M.D., affixes the Past President's pin to the lapel of Thad Moseley, M.D.

Mrs. Thad Moseley accepts the official portrait of her husband from Dr. Moseley's successor as President, Vernon B. Astler, M.D.

New President Vernon B. Astler, M.D. (left) congratulates his predecessor, Thad Moseley, M.D., on the accomplishments of his presidency.

and who has proven himself ready for the job. At this time I would like for Dr. Vernon Astler to come forward."

Dr. Moseley presented to Dr. Astler, the incoming President, the President's Gavel and Plaque.

Dr. Astler then presented to Dr. Moseley the past president's pin.

Dr. Astler then requested Dr. Ferguson and Dr. Reinstine to accompany Mrs. Moseley to the podium where he presented Dr. Moseley's portrait to her.

Dr. Astler introduced his wife, Diane, and his children, Lynn, Leslie, and Doug.

(The text of Dr. Atler's remarks were published in the June issue of The Journal)

Dr. Astler announced that the Board of Governors meeting would be held in the Pan American Room immediately following the adjournment of the House and would include all the Board Members—Drs. MaCris, Essrig, Walker, Hodes, Von Thron, Moseley, Cannon, Marshall, Nikolaus, Thames, Dever, Holland, Murray, Peek, Matthews, Cole, and all AMA Delegates.

Dr. Murray, Speaker of the House, called on Dr. Warren Quillian to give a benediction.

Dr. Quillian: "Heavenly Father, let us not forget, at the conclusion of these sessions, that we need Thee every day! Teach us to make up our minds and act. Give us the courage and ability to differentiate, and dare to undertake the important things. We ask Thy blessing upon the leaders who have been chosen to guide our policies during the coming year. Give us awareness of our responsibilities, and courage to serve ably, with good judgment, in every relationship. Amen."

The 1975 House of Delegates adjourned at 1:05 p.m.

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Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg.
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg
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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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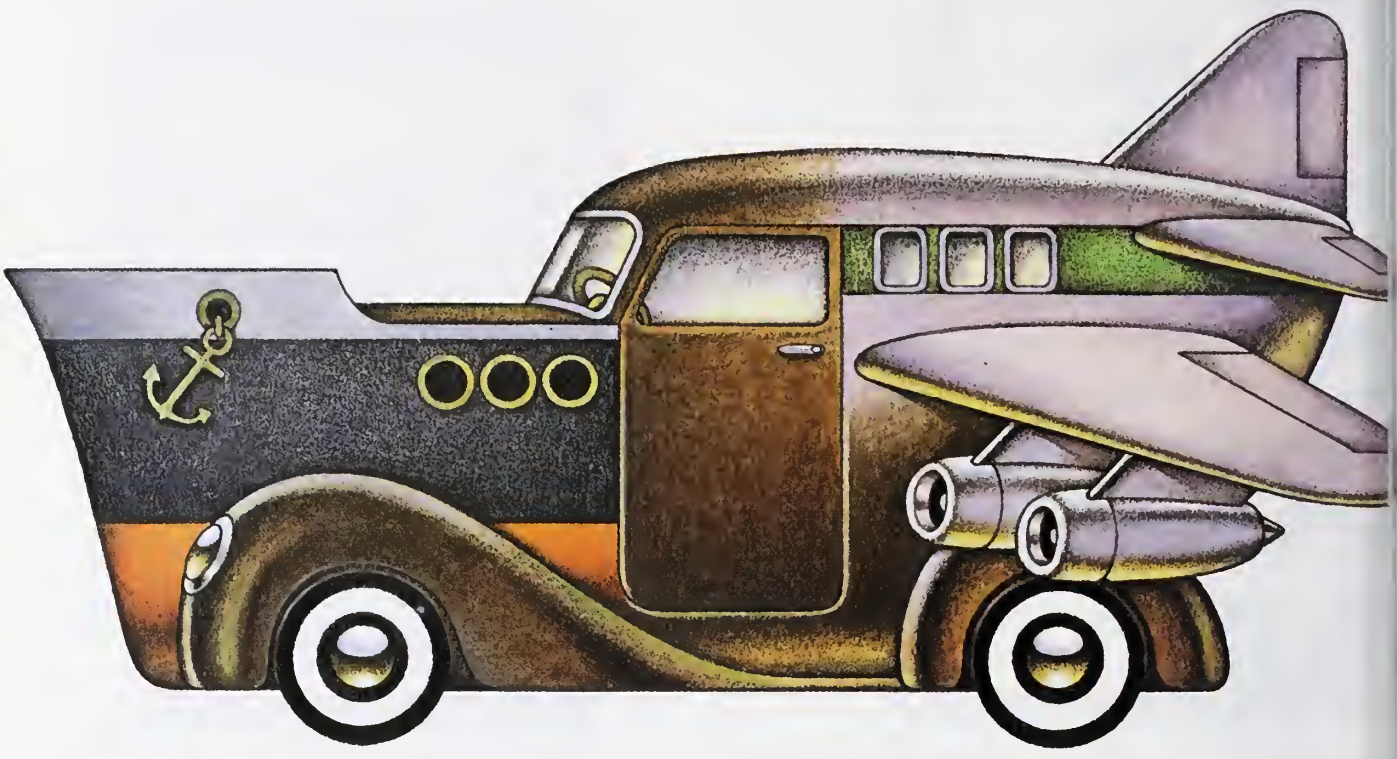

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CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Special Article

Florida Malpractice Act of 1975

Legislative Intent

Representative John R. Forbes

The 1975 Session of the Florida Legislature began in an atmosphere of crisis over the mushrooming costs of medical malpractice insurance and the concomitant threat to the continuing delivery of quality health care services to the citizens of our state. The tension was heightened when the Argonaut Insurance Company, Florida's largest single carrier of malpractice insurance, announced plans to discontinue writing policies in the state, thus posing the very real threat that some physicians and hospitals would be unable to obtain liability coverage at any cost.

The legislative committees that were assigned the task of developing solutions to the malpractice crisis quickly discovered that the spiraling insurance rates were actually the end result of a complex array of problems in the medical malpractice field. They realized that their scope of action had to go far beyond the temporary amelioration of the rate crisis and must address the root causes of the problem if long-term solutions were to be effected. Many of the dilemmas in the health care field that resulted in higher insurance rates were generated in the rapidly developing field of malpractice law. New legal doctrines, as well as new extensions of old doctrines, combined with a body of statutory law that did not accurately reflect the issues of modern health care, created a climate in which a physician was required to practice his profession without reliable guidelines as to how to avoid future liability. The legal system placed a premium on defensive medicine as opposed to the best long-term interest of the patient by failing to set determinable standards of care and treatment. Modifications in the legal system which would provide the practitioner with a clear knowledge of his duties and obligations while protecting him from undue pressure from frivolous actions were clearly in order. Furthermore, there was an obvious need for new legal procedures to expedite the handling and settlement of serious claims while reducing the exorbitant costs of malpractice litigation.

Another major contributing factor to the acceleration of insurance rates was the increasing incidence of claims based on malpractice-related medical injuries. It is true that some increase in such injuries is inevitable, given the tremendous growth in Florida's population and the increasing frequency of physician/patient contacts as well as the growing propensity of our citizenry to litigate over any injury whether real or imagined. It is also true, however, that there are a few physicians who practice in an incompetent manner. It is the actions of these practitioners (or "malpractitioners") that contribute to the unbearable insurance rate increases for the vast majority of Florida's physicians who are unquestionably competent and dedicated to their profession. Long-range solutions to the "malpractice crisis" required new methods of identifying the incompetent. Furthermore, procedures were needed to rehabilitate the malpractitioner where possible, in order that he may be of real service to the public.

The Legislature also realized that even the best long-term solutions to the causes of high insurance rates were not adequate to solve the immediate crisis of skyrocketing rates with no leveling in sight. Responsible members of the medical community were seriously considering curtailing or even suspending practice unless reasonable relief could be obtained. It was therefore necessary for the Legislature to develop measures which would guarantee the continuing availability of malpractice insurance in Florida and which would offer the practitioner a variety of means to reduce, or at least stabilize, the amount he must pay to protect himself and his assets from liability based on a professional malpractice claim.

Rep. Forbes is Chairman, Committee on Commerce, Florida House of Representatives, Tallahassee.

In May, 1975, the Florida Legislature passed the Medical Malpractice Reform Act of 1975. This Act represents a comprehensive approach to the plethora of problems which comprise the "malpractice crisis." It was the result of weeks of effort by legislative committees and staff working in close harmony with representatives of the medical, legal, and insurance communities. It combines the best ideas of legislation generated in other states with concepts originated here in Florida to provide a far reaching, multi-faceted body of legislation which may well serve as a model for other states.

The goals of the Legislature in passing the Act can best be summarized as follows:

1. Provide immediate relief by making medical malpractice insurance available and by providing the practitioner with a variety of options for protecting against liability.
2. Modify the existing body of personal injury law to provide statutory duties and obligations as to standards of care and conduct for practitioners, and develop new legal mechanisms to deal with the unique area of medical malpractice liability.
3. Reduce the incidence of medical malpractice by providing closer preventive supervision and by expanding sanctions to include remedial and rehabilitative disciplinary actions.
4. Create a continuing body which will evaluate the workings of the Act in ameliorating the problems and which will develop and recommend new solutions as necessary.

The remaining sections of this article will describe the provisions of the Act by which the Legislature sought to accomplish these goals.

I. *Providing an Insurance Market.*—Perhaps the most dramatic immediate effect of the Act is to assure the availability of medical malpractice insurance in Florida. Additional provisions in this area will tend to stabilize insurance rates while providing the practitioner with a variety of options in securing necessary coverage. Major provisions include:

A. A joint Underwriting Association (JUA) composed of most types of liability insurance carriers is created for purposes of writing medical malpractice insurance. The concept behind the JUA involves the apportionment of the risks among a number of carriers, much along the lines of the joint underwriting pool for high risk drivers in automobile liability insurance. The JUA will exist for a period of three years and is established as a temporary device to assure an insurance market in Florida. Policies of various limits will be available from the JUA to insure adequate coverage to all health care providers.

The operations of the JUA will be supervised by a board of governors which will include representatives of the participating insurers as well as a physician, a hospital administrator, an attorney, and the State Insurance Commissioner. Rates for insurance obtainable through the JUA will be determined on the basis of a number of factors, including loss history, geographic locale, and the type and status of practice. If an underwriting deficit occurs, the JUA can levy a limited deficiency assessment against policyholders and, if necessary, against participating insurers.

It is not anticipated that the JUA will cause insurance rates to drop. What it should do, however, is stabilize rates while providing insurance coverage to doctors and hospitals who otherwise would be unable to obtain coverage.

B. The ability of groups of physicians or hospitals to totally self-insure is significantly expanded under the Act. Groups may now be formed specifically for purposes of self-insurance and need not be in existence for two years before self-insuring.

C. One of the most original and perhaps far-reaching provisions of the Act establishes a Patients' Compensation Fund and allows physicians and other health care providers the opportunity to limit their liability through participation in this Fund. The liability of participants in the Fund is limited to $100,000 per occurrence with the balance of any judgment in excess of this amount being paid from the Fund.

All state-licensed hospitals must participate in the Fund unless they otherwise prove financial responsibility in the amount of $10,000 per bed up to a $2,500,000 maximum. Participation by physicians is entirely optional; however, those who do not choose to participate naturally do not receive the benefit of the fixed liability limits of $100,000.

Participating physicians must show financial responsibility in the amount of $100,000 through one of a number of means, including becoming self-insured, obtaining primary insurance coverage, or posting a bond. In addition, there is an annual assessment which must be paid into the Fund. The amount of this assessment for the first year of operation will be $1,000 per participating individual and $300 per bed for hospitals. In subsequent years, there will be a base rate of $500 per individual and $300 per bed for hospitals plus an additional assessment based on three classifications of practice in each of two geographical areas of the state as well as a fourth category based on individual risk ratings for hospitals.

If, in a given fiscal year, there is a deficit or projected deficit in the Fund for that given fiscal year, the Insurance Commissioner may levy a deficit assessment against those participating in the Fund for that fiscal year. For example, if a deficit occurs in the Compensation Fund in the fiscal year 1978-1979, the deficit assessment will apply against only those participants who paid their annual assessment for that fiscal year and not against participants from prior years, even if the cause of some of the claims causing the deficit originated in a prior year. This provision insures that participants will know the full extent of their obligation to the Fund at the end of a given fiscal year and need not worry about additional assessments in years in which they do not choose to participate in the Fund.

The Fund is to be maintained by the Joint Underwriting Association described above, and is subject to the supervision of its Board of Governors. It will be maintained at a level of up to $25,000,000, and no person will be able to recover more than $1,000,000 from the Fund in a given year. Any claims in excess of this amount will be paid off in subsequent years.

II. *Modification of Legal Doctrines.*—As mentioned above, one of the major causes behind the upsurge in malpractice claims and thus in insurance rates is the dynamic expansion of the area of the law which relates to medical malpractice. The development of new theories of liability and the extension of old ones leave the practitioner in a quandary as to the extent of his legal duty in a given situation. In addition, other legal practices which have developed over the years have the practical effect of adding to insurance rates due to their effect in inflating claims. Last, our present legal system is often too cumbersome to deal with malpractice claims in an efficient and inexpensive way, making litigation expenses a major factor in insurance rate bases and creating the need for a better way to handle malpractice suits. Provisions of the Act which are designed to meet these objectives are as follows:

A. Prior to this Act, an action for medical malpractice could be brought at any time within two years of the discovery of the injury, even if that happened to be ten or twelve years after the injury was inflicted. Insurance companies had no actuarily sound basis for predicting the number of claims to be generated during a given policy year and were forced to inflate rates to protect against claims made in future years. The Act amends the Statute of Limitations by providing that actions must be commenced within two years of the occurrence or two years of discovery, but no later than four years from the occurrence (unless it can be shown that the injury was intentionally concealed, in which event the period of limitation is extended forward two years up to a maximum of seven years from the date of the incident which gave rise to the injury).

This provision creates a definite time period in which claims must be made and thus establishes a much more reliable basis for predicting future liability. It should result in insurance rates that provide an accurate reflection of potential claims as opposed to liberal projections of possible losses.

B. A contributing factor in the growing public propensity to press for larger malpractice awards is the large amount of publicity that surrounds the filing of a huge claim against a physician. All too often, these claims are grossly inflated by large amounts of general damages (pain and suffering, etc.) in addition to the actual "specific" damages (medical expenses, lost wages, etc.). While the average medical malpractice verdict in Florida is only around $16,000, the publicity surrounding these large claims leads the public to believe that this average is many times this amount. Under the provisions of this Act, the dollar amounts stated in complaints in future claims will be limited to damages claimed for actual losses as opposed to pain and suffering, expected loss of earnings and the like. Only at the trial can figures as to these latter damages be dealt with, thus avoiding exaggerated pre-trial publicity as to these amounts.

C. Many times a patient interprets a physician's words of encouragement or expectation as being guarantees of the success or safety of a given medical procedure. When the results do not meet the patient's expectations, he will sometimes sue the physician based on breach of contract by alleging that the physician did not produce the promised results. In most cases of this nature, the negligence of the physician is not an issue—merely his failure to perform up to the patient's expectations.

The Act provides that any actual guarantees of results must be in writing and must be signed by the physician before the patient may bring an action based on breach of contract, thus bringing such agreement under the Statute of Frauds. This

will provide a tangible evidentiary basis for deciding a case when an agreement actually does exist, as opposed to the memories of the parties as to what was said by whom. Furthermore, it obviously protects physicians against claims in the vast majority of incidences where no guarantees or promises were ever made.

D. Much of the recent development in the area of medical malpractice law concerns the doctrine of "informed consent." A physician must inform the patient as to the expected results and the potential risks involved in a given medical procedure to the extent necessary so that the patient may have a solid factual basis for determining whether to consent to the procedure. Recent court decisions have extended this doctrine to require physicians to inform the patient as to exceedingly remote potential consequences of a given procedure instead of just the probable or even possible consequences.

The new Florida Medical Consent Law, which was incorporated into this Act, provides a statutory standard for determining whether "informed consent" has been given. The actions of the physician must be in keeping with the accepted standard of practice in the same or similar medical community and must provide the patient with a reasonable understanding of the risks and alternatives involved in a given procedure. No action based on lack of consent may be brought when this standard is met.

E. One of the more innovative provisions of this Act requires the submission of all medical malpractice claims to Medical Liability Mediation Panels, each to be composed of a doctor, a lawyer, and a circuit judge. The purpose of the panels is to weed out spurious claims and to promote the settlement of claims where liability actually exists. It is expected that these panels will reduce the number of claims that actually go to trial thus avoiding much of the high cost of litigation.

Members of each panel will be selected on a rotating basis from lists of doctors and lawyers within a given judicial circuit. Testimony will be taken and material evidence presented in basically the same manner as in a civil trial, but the regular rules of evidence need not be strictly adhered to. At the end of the hearing the panel will issue its opinion as to whether or not the physician was negligent in his care or treatment of the claimant. Moreover, the findings of the panel as to liability will be admissible as evidence in a subsequent trial should one be required.

If the panel determines negligence on the part of the physician, both parties may ask the panel to assist in determining reasonable ranges of damages to which the claimant is entitled. It is expected that this provision will promote out-of-court settlements of a large number of claims.

III. *Reducing the Incidence of Medical Injuries.*

If the panel determines negligence on the part and extent of medical injuries will lead to the reduction in malpractice insurance rates. The Legislature is seeking to promote these reductions by giving the Board of Medical Examiners and hospital medical staffs the tools they need to discipline those physicians who do not live up to the high standards of the profession. Furthermore, hospitals must seek out potential dangers to their patients in affirmative programs of preventing injuries before they occur.

Provisions of this Act which are designed to accomplish these objectives are as follows:

A. The Board of Medical Examiners is provided with new grounds upon which physicians may be disciplined, including incompetence negligence, willful misconduct, or judicial determinations of malpractice. In addition, the Board is given additional sanctions which are remedial in nature that may be imposed upon physicians who fail to live up to the standards of the profession. These sanctions include mandatory participation in continuing education programs and supervised practice under the auspices of another physician.

B. Similar disciplinary powers are also granted to hospital medical staffs in order that hospital privileges may be revoked, suspended, or curtailed for unprofessional or negligent actions. Among the actions that constitute cause for the imposition of sanctions are incompetence, negligence, or habitual and dangerous use of intoxicants or drugs. Procedures for the imposition of sanctions must afford due process to the physician against whom charges are brought.

C. Hospitals maintaining at least 300 beds are required by this Act to develop a comprehensive internal risk management program. The purpose of these programs is to actively search out the potential causes of patient injuries and to investigate the validity of patient grievances. Similar programs in other states have significantly reduced the incidence of hospital injuries.

IV. *Evaluation and Recommendations.*—The Florida Legislature realizes the difficulty in predicting the extent to which the provisions of the Act will affect the medical malpractice insurance problem. Therefore, the Act creates a blue-ribbon Medical Liability Insurance Commission which will continue to study the problem and to evaluate the effects of this Act. The Commission will report its findings and recommendations to the Legislature prior to January 1, 1976.

The Commission is composed of fourteen members including the State Insurance Commissioner, the Secretary of the Department of Health and Rehabilitative Services, three doctors, three lawyers, three insurers, and three lay citizens.

The Medical Malpractice Reform Act of 1975 represents a major effort on the part of the Florida Legislature to provide a comprehensive solution to the problems of medical malpractice insurance. It is anticipated that the provisions of the Act, working singularly and in conjunction with one another, will have a significant impact on stabilizing insurance rates while addressing the long-range problems that are the root causes of rate increases. The Act is not the final answer—further study and evaluation will be conducted on an on-going basis as the Legislature strives to develop an insurance system that provides adequate protection to the providers of health care services as well as to the citizens of Florida.

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Editorial

An Editorial Farewell

On a sunny spring day in 1955, a scholarly young man reported to his new place of employment at a suite of offices in Jacksonville's Florida Theatre Building.

He had just finished a stint as an executive trainee in the world of mortgage banking and real estate. Full of youthful zeal and enthusiasm, he was now prepared to point himself in a new direction.

THE JOB: Assistant Supervisor, Bureau of Public Relations, Florida Medical Association.

THE YOUNG MAN: Eugene Lewis Nixon III, Philadelphia born, South Carolina reared (A.B., University of South Carolina, Class of 1952).

A lot has changed since Gene Nixon hired onto the small FMA staff, which at that time included W. Harold Parham, Louise Rader and Frances Pesce, all of whom are still at the FMA headquarters today.

Doctors have come to Florida by the thousands, boosting the FMA from a relatively small organization to its present status as the eighth largest state medical association in the country today.

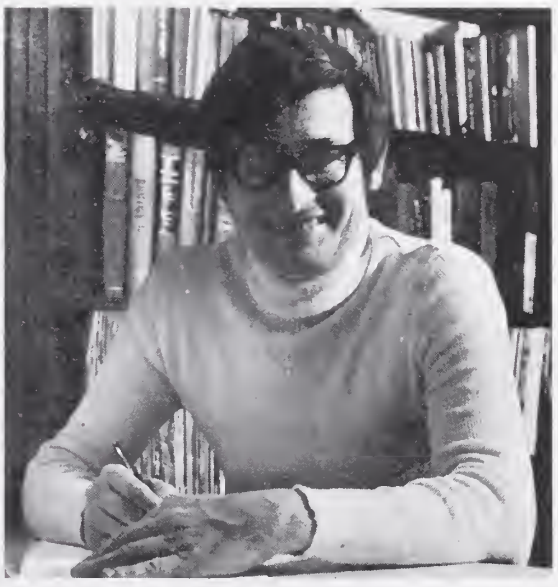
In the mid-1950s, FMA built its own headquarters on the banks of the St. Johns River. The phenomenal growth of Florida Medicine necessitated two later additions to the headquarters building.

Socialized medicine became a transcendent issue. The Forand bill . . . Kerr-Mills . . . King-Anderson . . . Medicare and Medicaid . . . national health insurance—these were some of the challenges medicine faced and is still facing.

As the vast body of medical knowledge grew and grew, continuing medical education received more attention from physicians, individually and in aggregate.

Charlatans and quacks descended upon Florida to reap their wretched harvest. There were problems associated with medical care in rural areas. Peer review developed and flourished.

As America entered the great recession of the 1970s, there were severe restrictions of medical fees under wage-price stabilization, and HMOs were promoted as the answer to unpredictable costs. Utilization review, PSRO, certified hospital admissions, cost containment legislation, and other letters and phrases spelled out increasing governmental involvement in the health care system.



Mr. Nixon

Bureaucratic presses churned out ream upon ream of rules, regulations, criteria, policies and guidelines frequently without prior consultation with the physicians affected.

Finally, there was the Great Malpractice Crisis of 1975, which spread like wildfire throughout the nation, rapidly being thrust into the courts and legislative chambers, and onto newspaper front pages.

Medicine had to confront each of these challenges.

Gene Nixon was a witness and participant in all of this and more.

While his principal interests were in the areas of education and services such as school health and scientific activities, hardly an FMA council, committee or program activity existing in the last two decades did not benefit in some way from his unceasing labor and wise counsel. The FMA Physician Placement Service, with which he worked daily, is recognized as one of the best of its kind in the country today.

He was in on the ground floor as FMA formalized its relationships with the voluntary health agencies and the allied health professions. He was active in rural health and in those programatic thrusts relating to the activities and programs of our elder citizens, as well as in the development of the Association's continuing medical education activities. He considers as his prime accomplishment the role that he played over two decades in elevating the scientific and educational activities to positions of prominence in the Association's overall program.

As an agent of the Florida Medical Association, Gene Nixon bore various titles during his illustrious career . . . Director of the Public Relations Department, Director of Scientific and Medical Services, Managing Editor of *The Journal*, Assistant to the Executive Vice President and Associate Executive Director for Programs.

As a one time Managing Editor of *The Journal*, Gene was the FMA staff member primarily responsible for the monthly preparation and publication of these pages. This job he approached, as he did all others, with an unceasing quest for complete accuracy and a perfectionist's demand for excellence.

In his limited free time, he spent many hours in recreational activities that involved the outdoors. He was an ardent protector of the environment.

Over the years, Gene Nixon came to know intimately hundreds of members of the Florida Medical Association. This legion of friends shall miss him in untold ways since he has resigned as of June 15 from the Florida Medical Association staff.

At this time, Gene Nixon is undertaking a new career with the Montana Foundation for Medical Care in Helena, Montana.

The editors of *The Journal* salute Gene Nixon and his wife, Norma, bid them farewell, and wish them all success and happiness under the Big Sky.

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October 5-18, 1975

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This course is designed primarily for internists who are preparing for certifying examinations. It is intended to provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Each subspecialty will be reviewed as described under "Schedule." Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts and references will be provided to all registrants, and audio-visual teaching aids will be available during the course for self-instruction and reinforcement.

The faculty is selected for ability to carry out advanced instruction on the following topics:

SCHEDULE

WEEK I—October 6-11, 1975			WEEK II—October 13-18, 1975		
October	6	Gastroenterology & Hepatology	October	13	Infectious Diseases
"	7	Cardiology	"	14	Rheumatology & Immunology
"	8	Pulmonary Diseases	"	15	Hematology
"	9	Endocrinology & Metabolism	"	16	Oncology & Genetics
"	10	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine	"	17	Renal Diseases
"	11	Neurology & Psychiatry	"	18	Hypertension & Acid-Base Disorders

LECTURES: The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10:00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 12:30 p.m. and from 5:00 to 7:00 p.m.

MEET THE FACULTY SESSIONS: Will be held every day from 2:30 to 4:30 p.m. and will consist of simultaneous small groups in which illustrated aspects of each subspecialty will be presented, followed by open discussions and topics not formally reviewed in the lectures.

SELF-TEACHING AUDIOVISUAL AIDS: Television sets with tape players and slide review projectors will be available throughout the entire meeting.

This course is accredited on an hour by hour basis toward the AMA's Physicians' Recognition Award and the Florida Medical Association.

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The Key Biscayne Hotel and Villas has reserved a limited number of rooms at special rates of $25/$28/$35 per day, European Plan. Modified American Plan is available at an additional charge of $11 daily per person. A hotel reservation form listing all the various types of rooms available will be promptly forwarded with the confirming registration. These hotel reservation forms are to be mailed directly to the Key Biscayne Hotel.

REGISTRATION FEE: $450.00 Checks payable to: U/MIAMI INTERNAL MEDICINE REVIEW COURSE

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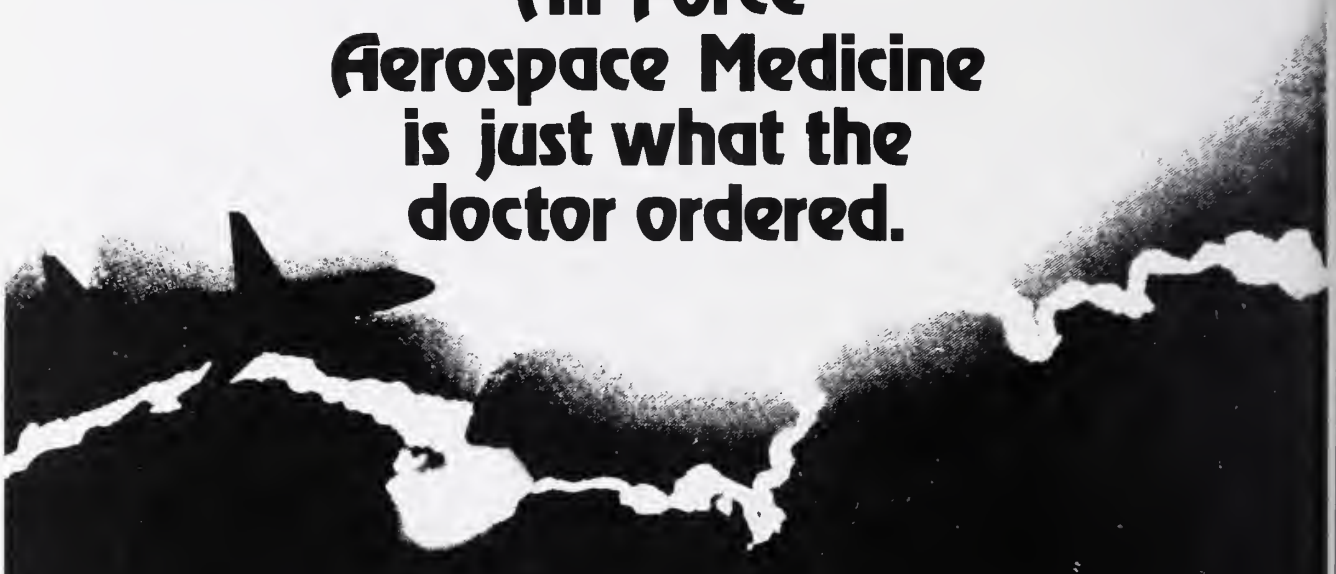

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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D. 640 Pages. Price $7.50. Los Altos, California, Lange Medical Publication, 1974.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Birth Defects, edited by Arno G. Motulsky and W. Lenz. 373 Pages. Illustrated. Amsterdam, Excerpta Medica, 1974.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Psychiatry in Primary Care by Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 Pages. Price $12.95. St. Louis, The C. V. Mosby Company, 1974.

Lifesaving, Rescue, and Water Safety by The American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Garden City, New York, Doubleday and Company, Inc., 1974.

In Defense of the Body by Roger Lewin, 146 Pages. Illustrated. Price $2.50. Garden City, New York, Anchor Press/Doubleday, 1974.

The Malnourished Mind by Elie A. Shneour, 209 Pages. Illustrated. Price $2.95. New York, Anchor Press/Doubleday, 1975.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Mental Retardation by editors: Julius B. Richmond, M.D., Chairman; George Tarjan, M.D., Robert S. Mendelsohn, M.D. 134 Pages. Price $2.00. Chicago, American Medical Association, 1974.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1957.

Current Surgical Diagnosis & Treatment, 2nd Edition, by J. Englebert Dunphy, M.D. and Lawrence W. Way, M.D. 1,123 Pages. Illustrated by Laurel V. Schaubert. Price $15.00. Los Altos, California, Lange Medical Publications, 1975.

Human Sexuality in Health and Illness by Nancy Fugate Woods, R.N. with a chapter by James S. Woods Ph.D. 232 Pages. Price $6.95. St. Louis, The C. V. Mosby Company. 1975.

Beneficient Euthanasia edited by Marvin Kohl. 255 Pages. Price $10.95 (hardcover) and $4.95 (paperback). Buffalo, New York, Prometheus Books, 1975.

HONORED FOR TEACHING EXCELLENCE . . . Hugh M. Hill, M.D., has been awarded the Hippocratic Award for Teaching Excellence by the graduating class of the University of Florida College of Medicine. Dr. Hill, who won a similar award six years ago, is Professor of Obstetrics and Gynecology and Associate Dean for Student and Alumni Affairs at the College of Medicine.

BROWARD COUNTY MEDICAL ASSOCIATION . . . has reached agreement with local lawyers on fees to be paid physicians for court appearances and depositions. For an office deposition, a physician will get $125 for the first hour or fraction plus $25 per quarter hour thereafter. Court appearances will be compensated at the rate of $150 per hour door to door.

ALEX F. SANCHEZ, M.D., of PLANT CITY . . . and his two sons put in a tour of duty together this spring at the Public Health Hospital in Eagle Butte, Mont. Dr. Sanchez was joined by sons Alex, Jr., who received his M.D. on June 1 from the University of Florida College of Medicine, and Robert, who graduated on May 17 from Creighton University Medical School. Both the Sanchez brothers began family practice residencies on July 1.

WILLIAM M. MADISON JR., M.D. . . . has been installed as President of the Florida Heart Association. The Jacksonville cardiologist succeeds Matthew H. Bradley, M.D., Miami Beach.

NATIONAL MEDICAL ASSOCIATION . . . will conduct its 80th annual convention at the Fontainebleau Hotel on Miami Beach, August 10-15.

CHARLES A. MONNIN, M.D. OF MIAMI . . . has been honored by the National Women's Movement of Bimini, B.W.I. for "dedicated services rendered to the people of Bimini, Bahamas, in the field of medicine and surgery."

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

JULY

Courses in Instruction in Coronary Care for the Practicing Physician, July 21-26, Jackson Memorial Hospital, Miami*

▶International Doctors in Alcoholics Anonymous, July 31-Aug. 3, The Breakers Hotel, Palm Beach. For information: Lewis K. Reed, M.D., 1950 Volney Rd., Youngstown, Ohio 44511

AUGUST

Upper and Lower Extremity Prosthetics and Amputation, Aug. 6-10, Miami*

▶National Medical Association, Aug. 10-15, Fontainebleau Hotel, Miami Beach. For information: E. Leon Cooper, M.D., 2109 "E" St., N.W., Washington, D.C. 20037

Courses of Instruction in Coronary Care for the Practicing Physician, August 11-16, Jackson Memorial Hospital, Miami*

Platelet Function and Disorders, Aug. 13, Baptist Hospital, Pensacola. For information: Richard Lawrence. M.D., Baptist Hospital, 1000 West Moreno Street, Pensacola 32501

Adriatic Discovery Air-Sea Cruise, Aug. 23-Sept. 5, departing Miami and Jacksonville. For information: Woman's Auxiliary, Florida Medical Association, P.O. Box 2411, Jacksonville 32203

Seminar on "Diseases of the Chest: Practical Problems," Aug. 28-Sept. 1, Great Harbour Cay, Berry Islands, Bahamas. For information: Miss Peggy Litka, Dept. of Radiology, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

SEPTEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 8-13, Jackson Memorial Hospital, Miami*

Florida Society of Anesthesiologists Annual Fall Meeting: Current Status of Inhalation Anesthetics, Sept. 13, Walt Disney World, Orlando. For information: Edwin S. Munson, M.D., Dept. of Anesthesiology, University of Florida, Box 721, J. Hillis Miller Health Center, Gainesville 32610

Teaching Conference in Pediatric Radiology, Sept. 17-21, Miami*

Tumor Immunology and Immunotherapy, Sept. 18, Mr. John's Steak House, Inverness*

Hand Surgery, Sept. 19-21, Miami*

Fall Meeting of the Florida Allergy Society, Sept. 19-21, Innisbrook Resort and Golf Club**

Facts and Fantasies About Diverticular Disease of the Colon, Sept. 24, Sacred Heart Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Second Annual Cardiovascular Symposium, Sept. 25-27, The Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P.O. Box 13494, Gainesville 32604.

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 29-Oct. 4, Jackson Memorial Hospital, Miami*

OCTOBER

Infection Control Practice—1975, Oct. 2-3, Cedars of Lebanon Health Care Center, Miami. For information: Thelma MacGregor, 1321 N.E. 14 St., Miami 33125.

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33205

Internal Medicine for the Practicing Physician, Oct. 3-4, Perdido Country Club, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Symposium on Emergency Cardiology and Medical Services, Oct. 12-14, Orlando Hyatt House, Orlando**

Arthritis and Orthopaedics, Oct. 17-19, University of Miami, Miami*

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel & Tennis Club, Key Biscayne*

Florida Society of Internal Medicine and the American College of Physicians Regional Meeting, Oct. 31-Nov. 2, Innisbrook Resort, Tarpon Springs. For information: James A. Winslow Jr., M.D., 1 Davis Blvd., Tampa 33606

NOVEMBER

Clinical Application of Intra-Aortic Balloon Pump, Nov. 14-15, Americana Hotel, Bal Harbour*

Human Union: The Health Practitioner Looks at Sexuality, Nov. 20-23, Americana Hotel, Bal Harbour*

JANUARY

Seminar in Pediatric Nephrology *III*: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 5-9, Miami*

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Pathology Symposium: Review and Recent Practical Advances, Jan. 20-23, Deauville Hotel, Miami Beach*

Anatomic Pathology Seminar, Jan. 23-26, Deauville Hotel, Miami Beach*

Miami Winter Symposia—Biochemistry, Jan. 1976, Miami*(Dates to be announced)

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

FEBRUARY

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Internal Medicine—1976, Feb. 15-20, Miami*

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

MARCH

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Miami*

Clinical Radiology Seminar, Mar. 23-27, Miami*

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

▶ National meetings being held in Florida.

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1975-1976

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Baker (See Nassau)					
Bay	Owen Reese Jr., Panama City	Frank T. Syfrett, Panama City	1st Tues.	0	50
Bradford (See Alachua)					
Brevard	James E. Carter, Cocoa Beach	Antonio Catasus, Merritt Is.	2nd Tues.	21	189
Broward	Diran M. Seropian, Ft. Lauderdale	Jerry D. Moore, Pompano Beach	4th Tues.	208	861
Calhoun (See Panhandle)					
Capital	Thomas P. Wood, Tallahassee	George H. Evans, Tallahassee	2nd Mon.	31	139
Charlotte	A. E. Annicchiarico, Port Charlotte	Stephen R. Roddy, Charlotte Harbor	3rd Mon.	1	57
Citrus-Hernando	Randall Jenkins, Inverness	Jose R. Berrios, Brooksville	3rd Thurs.	3	33
Clay	Susan E. Dorsch, Orange Park	Arthur D. Thaeler, Penney Farms	2nd Thurs.	0	37
Collier	Bruce Boynton, Naples	Eugene J. Linberg, Naples	3rd Wed.	2	76
Columbia	Henry E. Plenge, Lake City	Jose J. Goyenechea, Lake City	3rd Wed.	1	17
Dade	Pedro J. Greer, Miami	Marshall E. Hall, Miami	1st Tues.	334	2,469
DeSoto-Hardee-Glades	James T. Whitehurst, Wauchula	William D. Black, Wauchula	1st Tues.	7	14
Dixie (See Taylor)					
Duval	Emmet F. Ferguson Jr., Jacksonville	Yank D. Coble Jr., Jacksonville	1st Tues.	17	657
Escambia	John H. Whitcomb, Pensacola	John L. Pallin, Pensacola	2nd Tues.	32	197
Flagler (See St. Johns)					
Franklin-Gulf	J. Wayne Hendrix, Port St. Joe	W. T. Weathington, Apalachicola	Last Wed.	1	6
Gadsden (See Panhandle)					
Gilchrist (See Alachua)					
Hendry (See Palm Beach)					
Highlands	John B. Neal, Lake Placid	Glenn V. Hough, Sebring	3rd Mon.	1	32
Hillsborough	Harold L. Williamson, Tampa	John K. Petrakis, Tampa	1st Tues. & 3rd Tues.	124	507
Holmes (See Panhandle)					
Indian River	John H. Terry, Vero Beach	Edwin L. Lindsey, Vero Beach	3rd Tues.	12	55
Jackson (See Panhandle)					
Jefferson (See Capital)					
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Leon (See Capital)					
Levy (See Marion)					
Liberty (See Panhandle)					
Madison	Albertus F. Harrison, Madison	William J. Bibb, Madison	1st Tues.	0	4
Manatee	Sanford E. Elton, Bradenton	Robert E. Blackwood, Bradenton	4th Tues.	22	110
Marion	Steve H. Gilman, Ocala	James L. Stone, Ocala	3rd Tues.	12	61
Martin	John F. Powers, Stuart	Leon W. Powell, Stuart	1st Thurs.	6	42
Monroe	William M. Whitley, Key West	John D. White, Tavernier	3rd Thurs.	0	53
Nassau	Marshall E. Groover Jr., Jacksonville	Cecil B. Brewton, Fernandina Bch.	3rd Thurs.	2	15
Okaloosa	Stephen Z. Schilder, Ft. Walton Bch.	Samuel M. Atkinson, Ft. Walton Bch.	3rd Tues.	6	58
Orange	Clarence M. Gilbert, Orlando	Wm. F. Eckbert Jr., Winter Park	3rd Wed.	97	535
Osceola	Robert E. McMillen, St. Cloud	Manuel Agustines, St. Cloud	3rd Wed.	0	25
Palm Beach	Dick L. Van Eldik, Lake Worth	Thomas Murphy, W. Palm Beach	4th Mon.	87	476
Panhandle	Grayson C. Snyder, Blountstown	Richard H. Schultz, Marianna	1st Thurs.	2	49
Pasco	Harrison D. Williams, New Pt. Richey	Harvey O. Kaiser, New Port Richey	2nd Thurs.	17	24
Pinellas	Richard C. Trump, Madeira Beach	Kay K. Hanley, Clearwater	1st Mon.	132	589
Polk	Paul A. Tanner Jr., Auburndale	George W. Butz Jr., Winter Haven	2nd Wed.	20	281
Putnam	J. C. Kitaif, Palatka	I. Ahmad, Palatka	2nd Tues.	1	19
St. Johns	Richard J. Langston, St. Augustine	James E. Henderson, St. Augustine	3rd Tues.	2	36
St. Lucie-Okeechobee	Bernard D. Ross, Port St. Lucie	Bruce E. Mills, Okeechobee	3rd Thurs.	0	37
Santa Rosa	E. W. Sutton, Milton	Claude J. Barnes, Milton	1st Tues.	0	14
Sarasota	William L. Chapman, Sarasota	Norman J. Gengler, Sarasota	2nd Tues.	24	208
Seminole	Charles S. Dexter, Sanford	Robert L. Bevier, Sanford	3rd Tues.	1	45
Sumter (See Citrus-Hernando)					
Suwannee-Hamilton-Lafayette	Hugo F. Sotolongo, Live Oak	Andrew Bass, Live Oak	Last Mon.	0	6
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Mon.	0	9
Union (See Alachua)					
Volusia	James A. Carratt, Daytona Beach	Irwin Leider, Daytona Beach	2nd Tues.	5	197
Wakulla (See Capital)					
Walton	Lloyd L. McCormack, DeFuniak S...	E...			

Classified Ads

physicians wanted

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FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone Collect: (904) 973-6561.

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PART-TIME RADIOLOGIST: Older semi-retired boarded part-time radiologist preferred for private office and possibly part-time hospital work in beautiful West Palm Beach Area. Send photograph and credentials to J. L. Ackerman, M.D., P.A., 1717 North Flagler Drive, West Palm Beach, Florida 33407. No phone calls.

Miscellaneous

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THE
JOURNAL
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Medicine in the Florida Camps During the Spanish-American War — Great Controversies

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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in psychoneurotic
anxiety states
with associated
depressive symptoms

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AUGUST COVER—The cover was drawn by Dr. John W. Snow who, in addition to being a Plastic Surgeon in private practice in Jacksonville, is a gifted artist. This is the first of a series of creative cover pictures drawn by John Snow especially for The Journal to highlight the lead article in each particular issue. Dr. Snow's interpretation of his work is: The illustration depicts the indomitable Teddy Roosevelt and the charge of San Juan Hill, one of the decisive battles of the Spanish-American War, also the fact that battle casualties were only one-fifth those suffered from disease.

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President's Page

A Brief History of the Florida State Board of Medical Examiners

Since this represents the historical issue, I felt it appropriate to review some of the history of medical licensure in Florida. Portions of this material were supplied by my friend, Dr. George Palmer, Executive Director of the Florida State Board of Medical Examiners.

We repeatedly hear charges in these times that our profession does not properly screen, license, or discipline physicians. The record reflects the contrary view.

The earliest history of medical licensure and regulation was in 1828 in the territory of Florida. An act provided for a Board to examine prospective physicians annually for the protection of the public. This act was repealed three years later. In 1845, when Florida became a state, the Board was re-established. This Board did not have complete authority, and a physician could still file with the County Clerk a medical school diploma and a certificate signed by two practicing physicians in order to be recognized to practice medicine.

The first records we have in our possession of issuance of licenses to practice medicine in Florida are those of the District Board of Medical Examiners beginning December 12, 1889 and ending April 11, 1905 with certificate #197. By a legislative act signed by the Governor May 15, 1905, the regular Board of Medical Examiners for the state of Florida was created. This Board had seven members appointed by the Governor. They first met July 27, 1905, organized and adopted rules and regulations. Subsequently they met and conducted licensure examinations semi-annually through December 1920. From a newspaper clipping (not dated) one would have the impression that there were four (4) other "Boards" who served to license practitioners of the health arts other than graduates of approved medical schools. The gist of the article was that these Boards licensed individuals who received a diploma for a fee from "diploma-mills" and as a result there was a disgraceful situation in Florida. The article stated that there were five schools, some called medical colleges, each of which had its own Board under Florida law. The graduates of these four schools were automatically assured of licenses to practice. Only the regular Board of Medical Examiners required examinations for licensure of graduates of approved medical schools. The article also stated that this was four Boards too many and there "must be a composite Board of Medical Examiners composed of every school recognized in the realms of remedial or preventive medicine as possessing merit and value. This Board must have the power to examine severely the candidate before it, and should have the exclusive power to grant licenses or to withhold licenses. The legislature must pass a bill to put the licensing of would-be medical practitioners in the hands of one Board composed of accredited members of the accredited schools of medicine. The time has come when empiricism in Florida, at least with regard to the life and health of the people, must be put a stop to." The other four schools were systems of medicine such as homeopathy, naturopathy, eclectic systems of medicine and the like. It is of interest that this obviously represents an example of the press and the consumer doing for members of the healing arts what they could and should have done for themselves.

No doubt in response to this deplorable state of affairs in licensure of practitioners of medicine, the Florida legislature in 1921 created the present State Board of Medical Examiners composed of ten members. All members are and were MDs and graduates of approved medical schools appointed

by the Governor. The first meeting of this Board was held in Jacksonville on July 1, 1921 for organizational purposes and adoption of rules and regulations. For the first licensure examination given by this newly created Board was in August 1921 and forty-three (43) applications were approved. The Board conducted licensure examinations twice each year and also conducted business and hearings at these times.

So, you can see, even in these early times medicine was endeavoring to properly qualify and license practitioners in the healing arts and to upgrade the standards of medical care.

At a much later time, probably in response to consumer reaction, amendments to the Medical Practice Act began to occur which served to increase the quantity of physicians and to soften the standards for medical licensure. Some of the changes which occurred in following years are as follows: In 1953, the Medical Practice Act was amended and Board members received $10 per day while on official Board business. (this is still the per diem honorarium for Medical Board members). In 1955, graduates of unapproved medical schools could not be accepted for examination after August 4, 1955. In 1961, the Medical Practice Act was revised and brought up to date. In June 1960, an Executive Director was employed and an Assistant Director provided for. In 1969, government reorganization. Department of Professional and Occupational Regulations created. Board of Examiners and the Basic Sciences abolished. The "sick doctor amendment" to the Medical Practice Act was enacted and parts of the act were revised. In 1970, citizenship requirement for licensure eliminated. Declaration of Intention to become a citizen sufficient. Graduates of unapproved medical schools can be accepted for licensure if they are certified by an AMA approved Specialty Board. In 1971, licensure allowed by endorsement with National Board of Medical Examiners and with federation of licensing examinations (FLEX) if obtained within eight years of an application for licensure in Florida. Academic licenses for faculty members of state medical schools allowed for one year period, non-renewable. Amendment allowing certification of physicians assistants by the Board. In 1972, legislature passed a law stating no one could be denied examination for an occupation or profession because he is not a citizen of the U.S. A notarized statement of intention to become a citizen suffices. In 1973, a certificate to practice in an area of medical need of physicians allowed on a year to year basis without written examination if an applicant meets certain requirements.

Since July 1969, and largely because of the above changes in licensure requirements, the numbers of MDs licensed yearly in Florida has increased from between 500-700 annually to between 1,500-2,000 annually. Florida has ranked among the first five of the fifty states in MDs licensed. In 1974, there were approximately 12,500 licensed MDs in the state and over 8,000 additional licensed physicians living outside of the state of Florida. In 1963, there were approximately 5,700 MDs registered within the state and the population was approximately 5,633,000. By 1974, there were 12,500 medical doctors in the state and the population was approximately 7.5 million. So you can see the numbers of physicians has grown well in excess of the population growth of the state.

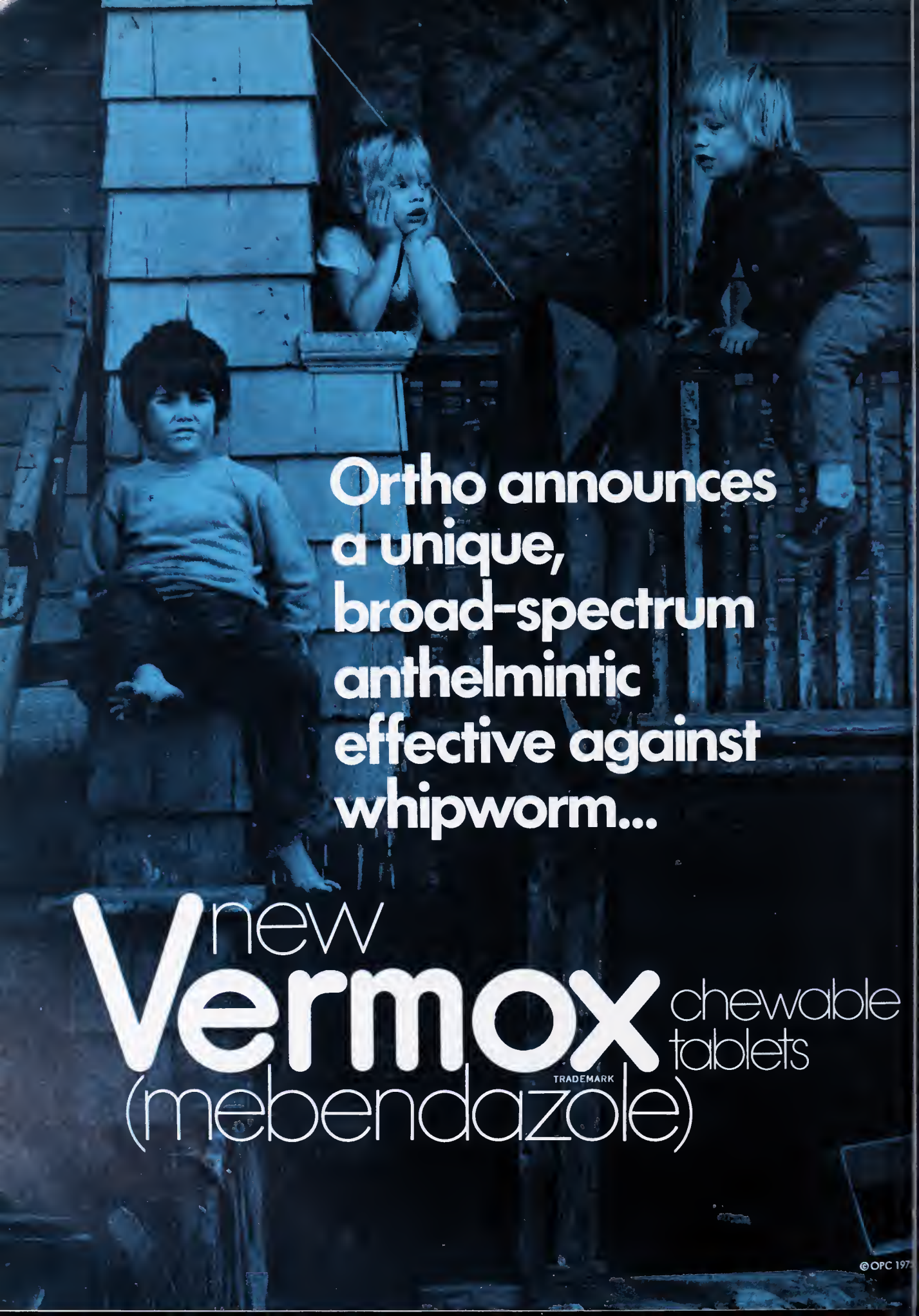
The message here in my mind is clear. If the members of our profession do not act properly and professionally in answering the medical needs of the citizens of this state we can expect others to carry out the necessary changes for us. As I stated in my induction speech, Dr. John McClenahan expressed it well when he stated, "It is because we have begun to act like merchants, and in many instances to observe the same hours, that the public expects us to be regulated by the same restraints."

The message here would seem to be that we not refuse new patients, or give them a six or eight week appointment time, or tell them to check the yellow pages for a doctor. The moral and humanistic values of our profession and the esteem which we have inherited as physicians would seem to dictate that we answer these needs or anticipate the needs being answered by other means and other health providers.

Lastly, I would say the Florida State Board of Medical Examiners has carried out 621 investigations from 1971 through 1974. 243 of these resulted in Board action and 379 resulted in investigation without requiring Board action. It is apparent that we physicians are policing our own and trying to assure *quality* medical standards in Florida.

Bibliography: Dr. George Palmer—personal communication

Vernon B. Astler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...and highly effective against roundworm, hookworm and pinworm in single or mixed infections

No dosage calculations — one simplified dosage, regardless of weight or age†

whipworm, roundworm, hookworm and mixed infections:
1 chewable tablet b.i.d. for 3 consecutive days

pinworm: 1 chewable tablet

If the patient is not cured three weeks after treatment, a second course of treatment is advised.

highly effective	Mean Cure Rate (Range)	Mean Egg Reduction (Range)	No. Patients	No. Studies
Whipworm (*Trichuris*)	68% (61-75%)	93% (70-99%)	211	(5)
Roundworm (*Ascaris*)	98% (91-100%)	99.7% (99.5-100%)	101	(2)
Hookworm	96% (—)	99.9% (—)	23	(3)
Pinworm (*Enterobius*)	95% (90-100%)	———	524	(7)

simplicity of administration patients can take the tablet at any time. It can be chewed, swallowed or crushed and mixed with food. No messy liquids to pour.

not a dye new Vermox* (mebendazole) chewable tablets will not stain clothes, teeth, feces, toilet bowls, etc.

convenient neither laxatives nor special diet required. Therapy does not interfere with daily activities.

well tolerated transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Vermox has not been extensively studied in children under 2 years of age, and thus, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women. (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Indications Vermox* (mebendazole) is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.

Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates meon (range)	68% (61-75%)	98% (91-100%)	96% —	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% —	— —

Contraindications Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* Vermox has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since Vermox may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults.

For control of trichuriasis, ascariasis, and hookworm infection, one tablet of Vermox is administered morning and evening on three consecutive days. For control of enterobiasis, a single tablet of Vermox is given.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied Vermox is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

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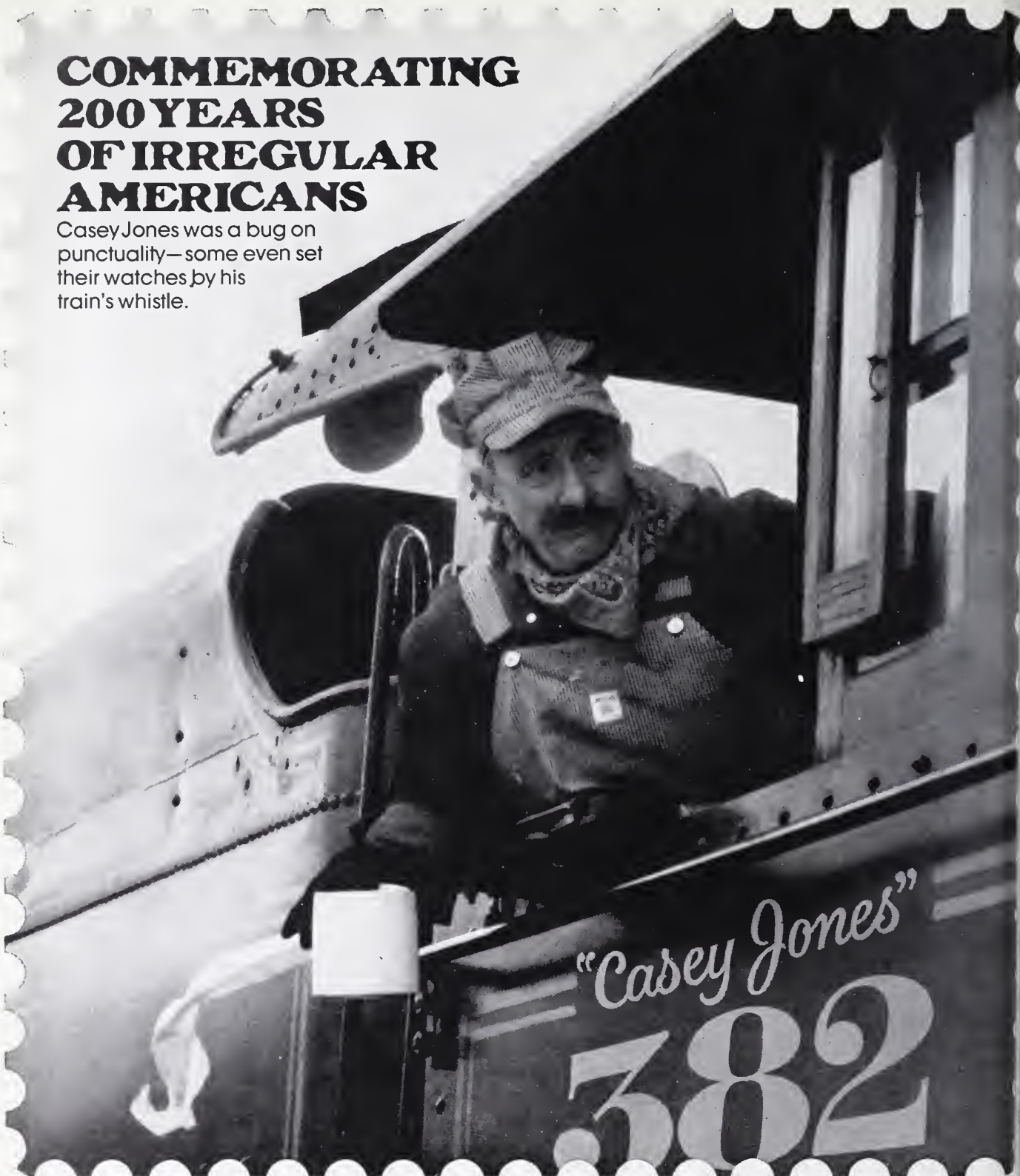

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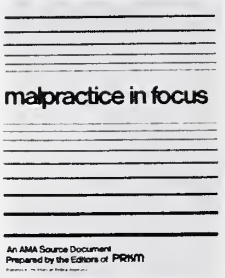

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Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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SECOND ANNUAL REVIEW COURSE

"Fundamental and Clinical Aspects of Internal Medicine"

October 5-18, 1975

KEY BISCAYNE HOTEL — KEY BISCAYNE, (MIAMI) FLORIDA

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SCHEDULE

WEEK I—October 6-11, 1975			WEEK II—October 13-18, 1975		
October	6	Gastroenterology & Hepatology	October	13	Infectious Diseases
"	7	Cardiology	"	14	Rheumatology & Immunology
"	8	Pulmonary Diseases	"	15	Hematology
"	9	Endocrinology & Metabolism	"	16	Oncology & Genetics
"	10	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine	"	17	Renal Diseases
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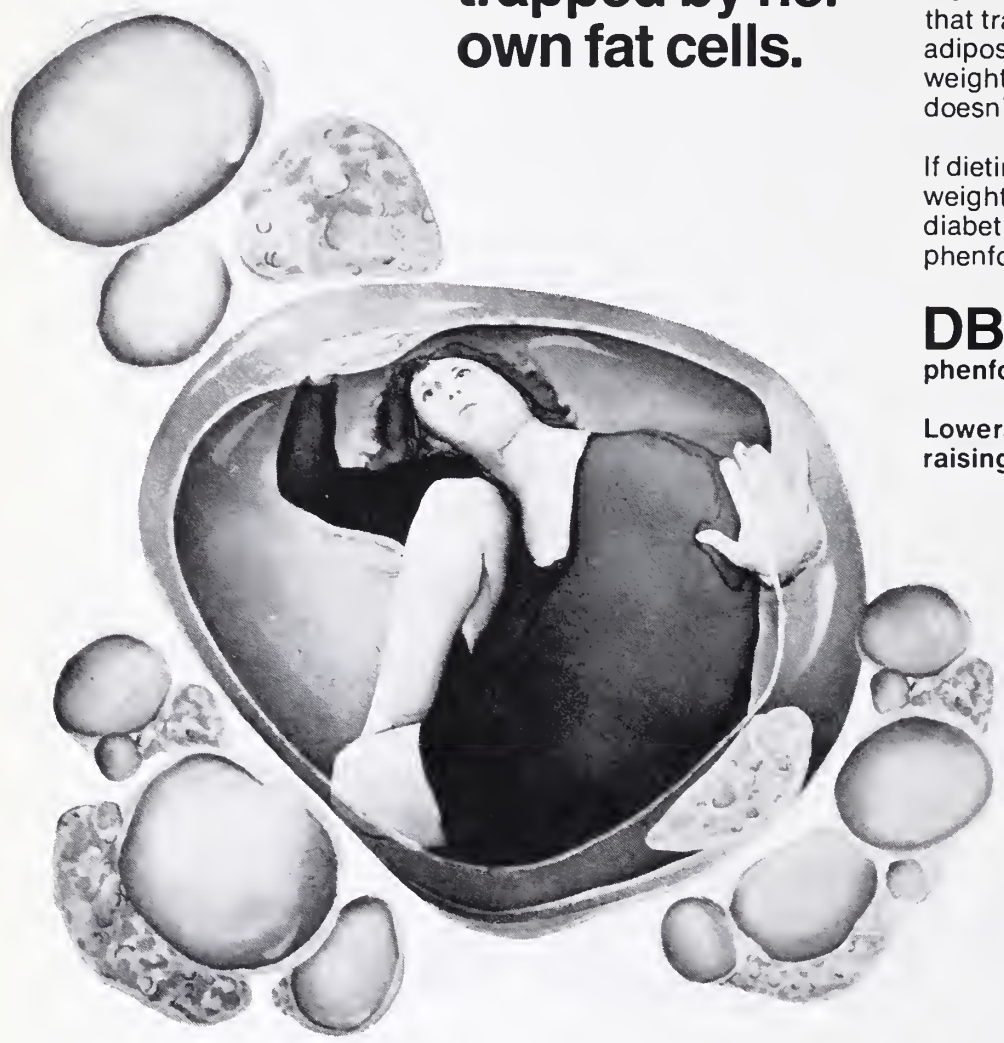

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b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
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d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.
e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
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AUGUST

Upper and Lower Extremity Prosthetics and Amputation, Aug. 6-10, Miami*

▶National Medical Association, Aug. 10-15, Fontainebleau Hotel, Miami Beach. For information: E. Leon Cooper, M.D., 2109 "E" St., N.W., Washington, D.C. 20037

Courses of Instruction in Coronary Care for the Practicing Physician, August 11-16, Jackson Memorial Hospital, Miami*

Platelet Function and Disorders, Aug. 13, Baptist Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 West Moreno Street, Pensacola 32501

Adriatic Discovery Air-Sea Cruise, Aug. 23-Sept. 5, departing Miami and Jacksonville. For information: Woman's Auxiliary, Florida Medical Association, P.O. Box 2411, Jacksonville 32203

Seminar on "Diseases of the Chest: Practical Problems," Aug. 28-Sept. 1, Great Harbour Cay, Berry Islands, Bahamas. For information: Miss Peggy Litka, Dept. of Radiology, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

SEPTEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 8-13, Jackson Memorial Hospital, Miami*

Florida Society of Anesthesiologists Annual Fall Meeting: Current Status of Inhalation Anesthetics, Sept. 13, Walt Disney World, Orlando. For information: Edwin S. Munson, M.D., Dept. of Anesthesiology, University of Florida, Box 721, J. Hillis Miller Health Center, Gainesville 32610

Teaching Conference in Pediatric Radiology, Sept. 17-21, Miami*

Tumor Immunology and Immunotherapy, Sept. 18, Mr. John's Steak House, Inverness*

Hand Surgery, Sept. 19-21, Miami*

Fall Meeting of the Florida Allergy Society, Sept. 19-21, Innisbrook Resort and Golf Club**

Facts and Fantasies About Diverticular Disease of the Colon, Sept. 24, Sacred Heart Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Second Annual Cardiovascular Symposium, Sept. 25-27, The Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P.O. Box 13494, Gainesville 32604.

Gastroenterology Today: for the Clinician, Sept. 26-28, Innisbrook Golf and Resort, Tarpon Springs**

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 29-Oct. 4, Jackson Memorial Hospital, Miami*

OCTOBER

Infection Control Practice—1975, Oct. 2-3, Cedars of Lebanon Health Care Center, Miami. For information: Thelma MacGregor, 1321 N.E. 14 St., Miami 33125.

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33205

Internal Medicine for the Practicing Physician, Oct. 3-4, Perdido Country Club, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Review Course on "Fundamental and Clinical Aspects of Internal Medicine," Oct. 5-18, Key Biscayne Hotel, Key Biscayne (Miami)*

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Symposium on Emergency Cardiology and Medical Services, Oct. 12-14, Orlando Hyatt House, Orlando**

Arthritis and Orthopaedics, Oct. 17-19, University of Miami, Miami*

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel & Tennis Club, Key Biscayne*

Florida Society of Internal Medicine and the American College of Physicians Regional Meeting, Oct. 31-Nov. 2, Innisbrook Resort, Tarpon Springs. For information: James A. Winslow Jr., M.D., 1 Davis Blvd., Tampa 33606

NOVEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Nov. 3-8, Jackson Memorial Hospital, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 14-15, Americana Hotel, Bal Harbour*

▶Southern Medical Association, Nov. 16-19, Fontainebleau Hotel, Miami Beach. For information: Mr. Robert F. Butts, 2601 Highland Ave., Birmingham, Alabama 35205

▶American Fracture Association, Nov. 16-20, Americana Hotel, Miami Beach. For information: H. W. Wellmerling, M.D., 600 Livingston Bldg., Bloomington, Illinois 61701

Human Union: The Health Practitioner Looks at Sexuality, Nov. 20-23, Americana Hotel, Bal Harbour*

DECEMBER

Florida Society of Ophthalmology Fall Meeting, Dec. 4-7, Innisbrook Resort and Golf Club, Tarpon Springs. For information: Susan Waits, Suite 346, Barnett Bank Bldg., Tallahassee 32301.

Courses in Instruction in Coronary Care for the Practicing Physician, Dec. 8-13, Jackson Memorial Hospital, Miami*

Non-Invasive Methods of Cardiovascular Diagnosis & Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Heart Association of Broward County, 440 N. Andrews Ave., Ft. Lauderdale 33301

JANUARY

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 5-9, Miami*

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Pathology Symposium: Review and Recent Practical Advances, Jan. 20-23, Deauville Hotel, Miami Beach*

Anatomic Pathology Seminar, Jan. 23-26, Deauville Hotel, Miami Beach*

Miami Winter Symposia—Biochemistry, Jan. 1976, Miami*(Dates to be announced)

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Eleventh Annual Postgraduate Course in Internal Medicine, Jan. 25-30, Hotel Fontainebleau*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC.

AUGUST, 1975 • VOLUME 62 • NUMBER 8

Historical Issue

Medicine in the Florida Camps During Spanish-American War

Great Controversies

SCHEFFEL H. WRIGHT, M.D.

It is doubtful that any war created more controversy than the Spanish-American War. This seems especially true when one considers that hostilities lasted only 15 weeks (April 25, 1898 to August 12, 1898) and that troops were engaged in actual combat only seven weeks (June 22, 1898 to August 12, 1898).

How did we become involved? Economics again? The young republic had $50 million invested in Cuba and enjoyed an annual trade of twice that amount.[1] "Yellow journalism" particularly in the papers of New York City fanned the flame of patriotism. At that time Joseph Pulitzer's *New York World* and William Randolph Hearst's *New York Journal* were in a circulation war and were wringing every ounce of sensationalism from each day's news to sell more papers. Such melodramatic assertions as "The Maine was Destroyed by Treachery — Split in Two by the Enemy's Infernal Machine—The Disease Ridden Deplorable Florida Camps" served that purpose well. Repeated Cuban incursions by juntas financed in New York also served to drag us to the brink. The editor of the *Tampa Tribune* stated it well when he wrote, "It would seem that the fever of belligerency increases with the distance from the front."

This "fever of belligerency" caught the United States Armed Services unprepared and launched them pell-mell into a program of expansion that resulted in an increase in the army from 26,000 to 273,000 in a matter of six weeks. The Medical Corp had to match this expansion with civilian volunteers, contract physicians and appointees, most of whom were ill-prepared for military life. Thus it is little wonder that a clamor of criticism arose that eventually resulted in arraignment by Congress of the Surgeon-General and indictment of the Army Medical Department on charges of "recklessness, neglect, inefficiency and incompetency."

The Medical Statistics

Now let us turn our attention to the medical aspects of this "splendid little war" as Ambassador John Hay characterized it. As in all wars disease killed more than bullets. The statistics quoted by the various commentators vary widely but the commonly accepted ones appear in Table 1.

Table 1

SOURCE	BATTLE DEATHS	DISEASE DEATHS
Surgeon-General[2]	968	5,438
Reed Commission[3]	379	4,784
Tebeau[1]	730	4,644

The vast majority of the disease deaths were attributed to typhoid fever although malaria is said to have attacked one in four of the soldiers[4] and yellow fever and dysentery accounted for other deaths. The Reed Commission[3] concluded that typhoid fever developed in one fifth of the soldiers in the national encampments in the United States. This may not reflect the true incidence for the same report notes that in the opinion of Commission members less than half the typhoid cases were correctly diagnosed. (Although the typhoid bacillus had been discovered by K. J. Ebarth in 1880 and had been shown to be the causative organism of typhoid fever, many practicing physicians refused to accept this discovery. Cultures of body excreta were not in common use and the Widal agglutination reaction was generally thought to be unreliable. Therefore, the diagnosis of typhoid fever was largely a clinical one.) Packard states[5] that typhoid "Epidemics developed in all of the camps and there were 13,770 cases recognized in the Eastern camps, Cuba and Porto Rico, with 906 deaths."

Although of any army of 273,000 men, only 100,000 are thought to have been stationed in Florida at one time or another, the only statistics relating to disease in the individual camps, with one exception, appear to be about Florida camps. Table 2 lists the number of deaths in the various camps.

Table 2

DISEASE DEATHS IN THE CAMPS	
Tampa[6]	56
Jacksonville[7]	245
Miami[8]	13
Chicamauga[9]	425

Definitive statistics on most of the camps in states other than Florida are not available, but the Reed Commission[3] after a thorough retrospective study concluded that every regiment enlisted for the Spanish-American War experienced cases of typhoid fever and in many instances it appeared before the regiments had left the encampments in their home states. This has led to the conclusion that the troops brought their typhoid with them to Florida.

Highlights of the Florida Camps

When in mid-March 1898 the War Department announced that camps would be established in the southeastern states the citizenry of Florida manifested little interest. However, Henry B. Plant who owned the Plant System, a combine of railroads and a steamship line that serviced the Flor-

United States Army Ambulance, Tampa 1898 (Courtesy of The State Photographic Archives, Tallahassee).

ida west coast, and Henry M. Flagler whose Florida East Coast Railway had reached Miami in 1896 quickly saw the opportunity to profit by this conflict and aggressively sought to have encampments in their areas.

Tampa was selected as a campsite on April 15, 1898 and next day the first contingent of troops arrived after many hours without food or drink. Barely had the train coaches stopped when the troops were ordered to fall in and march from Ybor City to the campsite at Tampa Heights. About half the soldiers were unable to complete the march because of heat stroke. Half-starved, dehydrated soldiers from the north clad in woolen uniforms were no match for the Florida sun. One soldier later remarked they had had "No coffee from Washington to Waycross and then coffee at twenty-five cents a cup."

As the troops began to increase in number, camps were located at DeSoto Park, Palmetto Beach, Port Tampa and behind the Tampa Bay Hotel. The city extended municipal services such as sidewalks, electric power lines, sewer mains and trolley lines to some of the camps, but on May 31, the Florida State Board of Health stopped sewer construction "as it was customary to prohibit any opening of the soil during summer months." This prohibition was based on the miasmatic theory of disease propagation which was in vogue at that time. According to this theory earth newly turned in the summer gave forth noxious effluvia capable of producing fevers such as malaria and yellow fever.

A consuming fear of both civil and military authorities was the possibility of an outbreak of yellow fever. General of the Army Nelson Miles on April 18 wrote to Secretary of War Russell A. Alger that he "was opposed to putting an army in Cuba during the sickly season." Miles was well aware of the dreadful toll yellow fever could take.

Florida citizens were no strangers to fevers but were calm and confident in their State Board of Health under the leadership of Dr. Joseph Yates Porter. In July a rumor circulated that yellow fever had occurred in the camp at Chicamauga and that three cases were present at Tampa. Anxieties rose rapidly and on July 8 Tampa was quarantined. Immediately the diagnostic acumen of the civilian and military physicians was challenged in an atmosphere of near panic.[6]

In an attempt to ascertain the facts firsthand, Dr. Porter immediately ordered a house to house inspection and it is said he did much of this himself! Three thousand two hundred fourteen houses were inspected and 25,000 people were examined but no yellow fever was found. The quarantine was lifted, but the rumors persisted until the report of a Presidental Commission cleared Tampa of all charges.

The country had been led to believe that 100,000 men could be landed in Cuba within one month of the declaration of war. Thus it was time to get a move on, so in the midst of the yellow fever flap at Tampa the commanding general there, William R. Shafter, was ordered to take 25,000 men to Cuba. As a manifestation of the confusion existing in the War Department at that time, these orders were cancelled and changed three times before they were finally carried out. In the face of a rumor that the Spanish fleet was lying in wait in the Straits of Florida, on June 14, General Shafter embarked 16,000 men on 35 transports, four tenders, one hospital ship and 14 naval escort ships.

Jacksonville was initially thought too far from the conflict to be useful but the city fathers must have persisted for on May 1, General Shafter ordered troops there and by September 31,000 men were encamped. The first troops encamped at East Springfield under the command of a nephew of the late General Robert E. Lee, General Fitzhugh Lee, who dubbed his camp "Cuba Libre."

The Jacksonville camps were the best in Florida partly because more time and care were exerted in picking and preparing the sites. Also the city, being larger than any other in Florida, provided better facilities for recreation and better means of policing and sanitation. Furthermore the initial troops assigned to Jacksonville were regular army divisions which were well organized, disciplined and had well staffed Medical Departments.

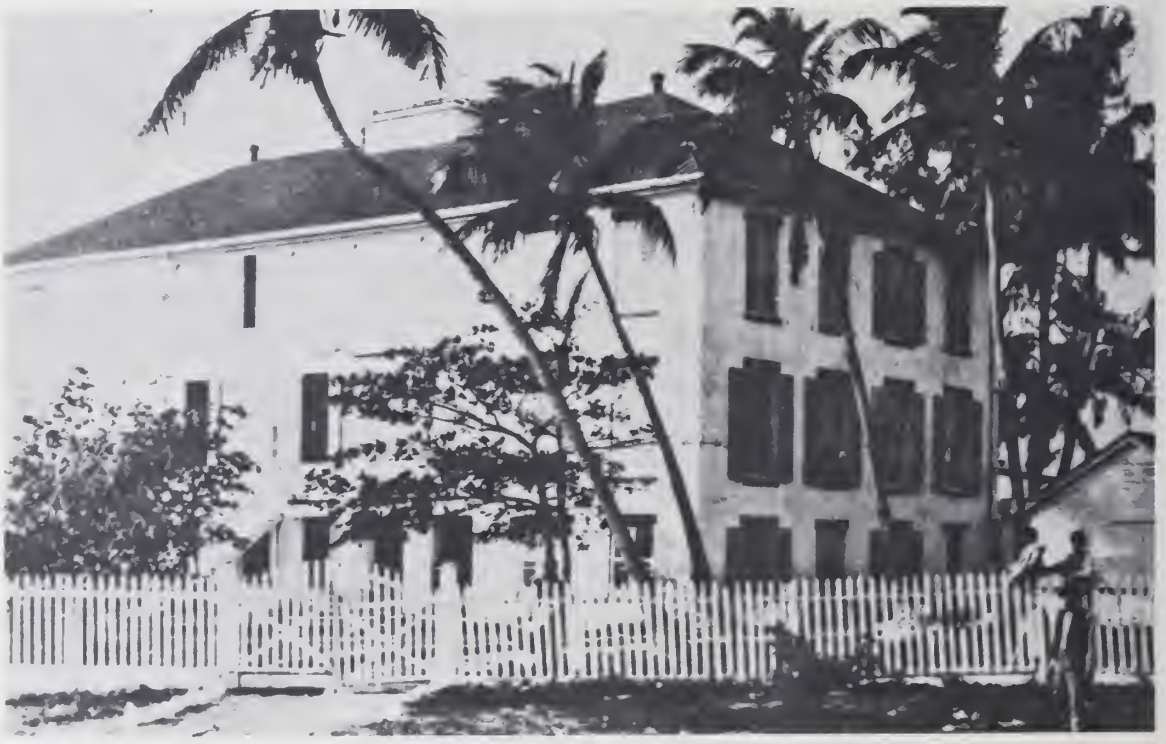
The city had dug deep wells providing an excellent supply of palatable water and had attempted to extend the sewer lines but summer arrived and again further digging was forbidden. The medical officers wanted to establish pit latrines, deep pits into which excreta were deposited then covered with a layer of dirt and lime each day, but city officials forbade this also. The city fathers insisted that excreta be deposited in barrels which the city hauled in wagons to the ends of the sewer where it was dumped into the sewer system. This cumbersome arrangement was later blamed for the typhoid epidemic suffered by the Jacksonville camps. This epidemic which ap-

peared in July consisted of 1,729 certain cases and 2,693 "certain and probable" cases. There were 248 deaths among the 31,000 troops. This figure does not accord with Table 2 which illustrates the difficulty in getting accurate statistics.

The medical officers of Camp Cuba Libre may have been the most innovative in the army of that day. Among their innovations was perhaps the first instance of the use of disposable materials in the care of the sick. Low cost mattresses and pillows were made of shredded palmetto fronds which were burned upon discharge of the patient. A convalescent center was established at Pablo Beach near Jacksonville and later sick troops from Miami were transferred to this facility.

The selection of Miami as a campsite was perhaps the most controversial of all the selections in Florida. Major General James Wade was sent to investigate Miami as a possible site on two occasions, May 19 and May 25, and each time he rejected it. However, Henry M. Flagler, whose Florida East Coast Railroad would benefit from the traffic, refused to take no for an answer. He instructed his superintendent, Mr. Goff, to prepare a campsite at Miami and meanwhile made contact with important people in Washington to whom he extolled the city's virtues. As a result no less a person than General Miles prevailed upon Mr. Alger, Secretary of War, and Miami was chosen.

The original plan was a rectangular camp the long side of which was to be along the bayfront extending from what is now Northeast Second Street to Northeast Sixth Street with three regiments on the bayfront and three just west of them —this area had been cleared at Goff's direction. However, when the troops arrived the plan was changed and two regiments placed on the bayfront while the other four regiments were extended west on uncleared land as far as the mainline of the Florida East Coast Railway. Thus four of the regiments were forced to spend a week clearing the land in the hot July sun which did not endear them to Miami. This change dictated by the camp commander, Brigadier General Theodore Schwan, also put these troops beyond the shallow wells and sewer system which had been prepared by Superintendent Goff. Goff had planned a system of wooden troughs by which the sewage could be sluiced into Biscayne Bay but these could not be effectively extended far enough from the bayfront to accommodate the units in the western part of the camp. Attempts to dig or blast pit latrines in the coral rock were not successful, therefore a "bucket system" was instituted. The half-barrels or buckets were supposed to be emptied each day but this was not always done and



United States Marine Hospital, Key West, c 1898.

the soldiers' acceptance of this system was not enthusiastic. Many soldiers "went to the woods" rather than make use of the provided sanitary facilities. Indeed, one officer stated that he could not go more than a few yards behind the tents without soiling his boots.

Another problem was that of drinking and cooking water supply. Goff had provided a number of shallow wells with hand pumps but these soon became contaminated by the raw sewage dumped on the ground and the pump handles were removed. The alternative supply was through pipes laid on the surface of the ground to the city water supply. The water appeared at the taps unpalatable and hot though apparently bacteriologically safe. By running the water through barrels of ice it was made more palatable but it retained a disagreeable taste.

Then to add to the soldiers' discomfort they were clad in wool uniforms in the midsummer heat and the mosquitoes and sandflies pestered them. One soldier wrote, "Here at Miami we have heat, mosquitoes and sandfleas (sic) that beat anything we have ever met. We even hang our hats on the mosquitoes at night!" Another one told his family back home, "If I owned both Miami and hell, I'd rent out Miami and live in hell!"[10]

Still another source of dissatisfaction was the lack of entertainment facilities in the small town of Miami. The most that could be had were shooting galleries, lemonade stands and the army canteens. Some of these canteens were dry and others sold beer and wines. It can easily be imagined which were the more popular.

The illness rate at the Miami encampment ran as high as 10% of the troops. It was subsequently said that the unpalatable water, hot climate, humidity, insects and lack of entertainment facilities probably contributed more to the unhappiness of the troops than did disease.[9] The Miami Metropolis[8] reported six deaths among the troops from typhoid, five from measles with complications and two from other causes.

Two army inspectors joined all the medical and line officers on the station in condemning the camp and finally the troops were ordered to strike camp and entrain for Jacksonville. It is said that four days after the order to leave was received the number of patients in the division hospital dropped from between 260 and 270 to 50 men![10] This astonishing recovery seems suspicious and it was later confirmed by the army with the comment that "they were probably suffering from boredom."

Educational Building, Convent of Mary Immaculate, Key West. (Courtesy of The Monroe County Public Library.)

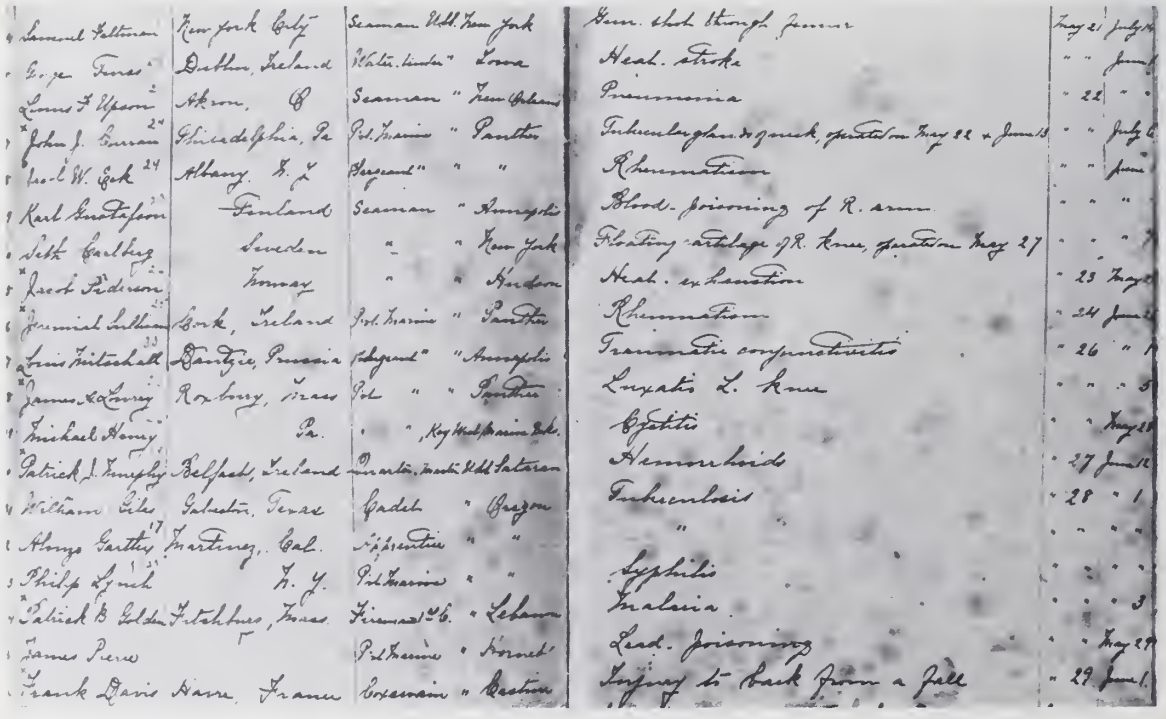
The camp at Fernandina received the best sanitary report of all those in Florida. The citizens of Fernandina and the railroad had aggressively sought the encampment of troops there and bemoaned their departure after a scant six weeks. The troops were housed at Fort Clinch which was well prepared to accept them. No statistics of illness or mortality are available but it was apparently a healthy location.

The Lakeland camp was really a satellite of the Tampa encampment. However, the location proved to be a wise selection and there were no reports of illness. Part of Lakeland's success was thought due to the fact that the soldiers stationed there were regular army with an excellent chain of command.

Despite the fact that Key West had a well established Navy base and a small Army garrison at Fort Taylor, it proved ill-prepared to meet the demands suddenly thrown upon it by the War for Cuban Independence. The perennial water shortage aggravated by a long drought which left the cisterns empty was especially a problem. This was met by building new water distilling plants. The new plants permitted the production of 50,000 gallons of potable water daily. Another problem was insufficient housing which caused crowding and attendant disciplinary problems. Over 100 newspaper correspondents added their share of the overcrowding and, hungry for something to write about, filled their home papers with unfavorable comments about Key West.

The Marine Hospital was well established in Key West long before the days of the Spanish-American War, but it was small and could not handle the influx of large numbers of casualties from Cuba. Recognizing this, Mother Mary Florentine, superior of the Convent of Mary Immaculate with the support of her order, offered the buildings of the convent and school for a military hospital. The offer was accepted, the school was closed on April 12, and work was begun immediately converting the classrooms to wards, the parlour to a dispensary and the convent offices to operating rooms and hospital administrative offices. Some 23 nuns offered their services in running the hospital and administering to the patients. The first patient was admitted on May 6 and during the three and one-half months the convent served as a hospital, 550 Army and Navy personnel were cared for. In addition to the nuns, the professional staff consisted of 13 surgeons, nine trained (female) nurses, and 50 Army and Navy stewards/nurses.

The hospital register shows the diagnosis, surgery performed and at times the outcome of most patients. Diagnoses range from one case of ingrown toenails and two of 'megrim" (migraine



Hospital Register, "Convent" Hospital, Key West 1898 (Courtesy of The Monroe County Public Library).

headache) to measles and malaria. There are approximately 68 different medical diagnoses and 26 different surgical diagnoses. The most frequent medical diagnosis is measles with 44 cases and the second most frequent malaria with 36 cases. Typhoid appears 16 times with two deaths. By far the most frequent surgical diagnosis is penetrating gunshot wounds of various parts of the body including the skull, chest and abdomen. Although deaths are recorded in the register, it is not known how consistently this was done. If one accepts that all deaths were recorded, the overall mortality in this hosptial must have been low.

The most common operation performed was a herniorraphy (probably inguinal) of which 12 were done. One appendectomy and several amputations are recorded. A liver abscess was drained on July 10—apparently successfully. On two occasions a hemorrhoidectomy was performed and on one occasion an operation was done for varicose veins. One knee was explored and a torn cartilage removed, three fistulectomies were done, and the parotid gland was excised on one occasion.

Only two psychiatric diagnoses are recorded: neurasthenia of which 12 cases are listed, and melancholia of which there are three cases.[11]

Toward the end of the summer three marines barracked in an unused cigar factory came down with an, at first, nondescript fever. A young, self-confident and very convincing naval surgeon, fresh from medical school, made a diagnosis of yellow fever and convinced his superiors and some of the town physicians. Immediately fear spread throughout the town and although Dr. Porter, Dr. William Murray of the Marine Hospital Service, and Dr. A. H. Glennan of the Public Health Service examined the cases and announced that it was not yellow fever, the Navy would not be convinced. All but the most essential Navy personnel were ordered aboard the Fleet and the entire Fleet steamed for northern ports. Within a few days the typical rash of dengue fever appeared and before the epidemic spent itself there were 6,999 cases of dengue in Key West with no mortality.[1,12]

This incident precipitated bitter antagonism between the civilian physicians and the State Board of Health on the one hand and the Navy on the other hand. The Marine Hospital Service took over all quarantine functions and were later blamed for the introduction of yellow fever into Miami, Port Tampa and Key West.

Lessons Learned

Surgeon General George Miller Sternberg became disturbed about health conditions in the Army camps in early July 1898. With approval of the Secretary of War he appointed a board of

Sailor's Ward, "Convent" Hospital, Key West 1898.

experts chaired by Dr. Walter Reed to investigate the factors involved. Their efforts resulted in a lengthy report which was particularly aimed at the problem of typhoid fever.[3] They concluded that "camp pollution was the greatest sanitary sin committed by the troops." Every regiment in the Army of 1898 experienced typhoid and among the volunteer regiments over 90% developed typhoid within eight weeks after they assembled in their home states. It was epidemic in both small and large encampments and just as prevalent in the Northern camps as the Southern camps. The evidence they gathered did not support the miasmatic theory of disease nor a theory that the colon bacillus was somehow transformed into a typhoid bacillus. Some camps, they felt, were not wisely located making them impossible to keep sanitary. They found the water supplies were generally good until contaminated by poor camp sanitation. In only one instance was it possible to show a contaminated water supply as the cause of a typhoid outbreak and this left the Army Medical Department puzzled for at that time contaminated water supply was thought to be the only method of conveyance in typhoid epidemics. However, the data clearly showed that the frequency of typhoid cases was in direct relation to the method used for disposal of excreta. Thus typhoid fever was most prevalent in those camps where the tub or bucket system was in use and little care was exercised in properly disposing of the contents of the buckets.[3]

The rapid expansion of the Army with inadequate planning and insufficient time to train the men led to poor discipline which in turn added to the disease problems. Furthermore, the enlistment of large numbers of civilian physicians with little knowledge of camp hygiene was a factor to be considered. Also, frequently the line officers ignored the recommendations of the medical officers in matters relating to camp hygiene. Most of the nursing in the general hospitals was done by enlisted men assigned from the line who had no training and often little interest and aptitude in the care of the sick.

In summary, it seems that most of the criticism aimed at the Florida camps was unjustified. The difficulties which arose were the result of hasty and inept decisions, lack of preparedness, rapid mobilization of thousands of men, limited knowledge and experience of most of the officer personnel, and exaggerations of an overly aggressive press. Florida's reputation as a health resort was tarnished but the state gained by the attention focused upon it and the facilities installed at such places as Key West, Tampa and Pensacola. That this small and undeveloped state was able to cope with the massive invasion must be attributed to the staunch and dedicated character of its people. "That there was no outbreak (of yellow fever) in 1898 is perhaps correctly attributed to the careful work of Dr. Joseph Porter."[1]

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73rd Annual Meeting of Florida Medical Association Adjourns to Havana

William W. McKibben, M.D.

Three days devoted to scientific papers, mostly in the Miami Auditorium in Bayfront Park . . . to fishing trips out into the 600 varieties of tropical fish in the Gulf Stream . . . to a handicap golf tournament at the Country Club . . . to skeet and trap shooting at the Peckaway Skeet Club . . . to Alumni and Fraternity suppers . . . to Technical Exhibits . . . to motor boat trips among the Beach Islands . . . surf and sun baths at the beaches . . . up the River to the Seminole Indian Village . . . Snake and Alligator Farm . . . to the Submarine Gardens and the $10 million Deering Estate . . . to the exotic Hialeah, Tropical and Gulfstream Race Tracks . . . to the top of the 22-story City Hall and Court House, showing the vast Everglades, Keys, Biscayne Bay, Causeways and Beaches and finally, Greater Miami, in its tropical setting of beauty at our very feet.

Monday evening by moonlight, a delightful floor show with music and dancing (not stag) was staged at the Coral Gables Country Club under the coconut fronds.

Tuesday night the annual banquet was celebrated at the swanky Surf Club. Characteristic of Miami, the gentlemen were in formal, sport and business suits; the southern belles were gorgeous in their lovely evening gowns. Cocktails and daiquiris flowed freely adding joy to the gala occasion. Never was orchestral music smoother or more appealing. The stringed instruments told your feet just what to do, and when. With the top ceiling awnings drawn back, many dancers dreamily gazed up at the tropical moon and stars. Nearby, the gentle ocean waves lapped at the sandy beach.

Wednesday evening at seven "The Florida" of the Peninsular and Occidental Steamship Line pulled out from the Miami docks with 30 or 40 doctors and their wives on board bound for Havana. We reluctantly left the bow, or port gunwale, where we were watching the autos speed along the MacArthur Causeway toward Miami Beach. The steward came down the deck ringing the dinner bell with both hands. Dr. and Mrs. George Austin, my daughter, Darthea, and I kept leaving our table despite the roast turkey to gaze from the porthole at the disappearing Miami, Miami Beach and government breakwater.

Soon everybody was out on deck again viewing a calm sea, a yellow moonlit path towards Fowey Rock's blinking light. Fast slipping behind us off to the northwest was the brilliant illumination of "The Magic City" while still further up the coast were the colorful Beach lights slowly fading away into the distance. The tropical night was so quiet and the Florida Straits so calm that dancing in the cocktail room was pleasant and smooth.

A good night's sleep with the so-called trade winds on our port side and a fan beside our open windows, plus a substantial breakfast, ushered in what proved to be a never-to-be-forgotten day of varied sights and experiences.

William Watson McKibben, M.D.

William Watson McKibben (1874-1968), a prominent Coral Gables pediatrician for many years, assisted by his daughter, Darthea Kreeger Ayars, vividly describes the gaity of pre-Castro Havana, "The Paris of the Americas." The occasion was a postconvention tour following the Seventy-Third Annual Meeting of the Florida Medical Association in Miami, April 21-23, 1947.

Varied Sights and Experiences

On leaving the dining salon, the passengers lined up at the top deck bow gunwale gazing at the distant blue haze of mountains steadily becoming clearer on the coast of Cuba.

"Cuba, the Holiday Isle, where you live a short 'star vacation' as in a dream; where you open a parenthesis in Life's prosaic reality and fill it with the poetic adventure of a breathing spell in a romantic land where all is different; where sun, music, dancing and other recreations will find you without care (sans souci)."

Havana, "Paris of the Americas," offers throughout the year its continental diversions, night clubs, casinos, race tracks, a cultural life, fashionable beaches—all in the peculiar atmosphere of a colonial city and a modern metropolis.

As "The Florida" steamed in closer, like the desire for over-ordering at a cafeteria, we let those many possibilities and longings sink into the back of our minds and dealt with what was directly before us. Frowning down on us, and most impressive of all, was the historic and ancient Morro Castle (Castillo del Morro), which with the Cabona Fortress could a tale unfold of cruelty and suffering that would make each particular hair stand on end, even to more recent date when our own friend, Dr. Carlos Lamar, was confined there for 85 days as a prisoner of civil war in 1933.

There was an hour's delay in the Havana Custom House before our auto rolled us up to the Maine Monument and to the huge two-towered Hotel Nacional, impressively standing on a prominent bluff overlooking the Gulf of Mexico on three sides. "Gorgeous" best describes its interior, the largest and most costly hostelry in this great city of almost a million people.

Unpacking, a swim and luncheon at the out-of-doors gaily colored Tropical and Venetian Pools was followed by an afternoon sightseeing trip in the gay, fascinating and foreign city in an eight-passenger car containing Dr. and Mrs. Walter Jones, Dr. and Mrs. Duncan Owen, Dr. and Mrs. Joe Stewart, and my daughter, Darthea, and me.

We visited Old and New Havana, La Merced Church (1792), La Fuerza Fort (1544), Columbus Chapel, Cathedral Plaza, Old and New Presidential Palaces, Prado Promenade, Malecon Driveway, Orphanage Asylum, Corona Cigar Factory (where we saw them making the world famous Havana cigars by hand), Vedado aristocratic suburb, homes and tennis courts, Colon Cemetery, and finally the Trocadero Rum Distillery, shown making rum from sugar cane molasses, pineapples,

Reception Hall of the National Capitol, Havana.

bananas, etc. The guests were served many samples for tasting and generous famous daiquiri cocktails.

Finally, the "piece de resistance" of all, speaking figuratively, was the $17 million "Capitolio" on Fraternity Square, machine-gunned the week before. Started in 1925, it took years to build. It covers two blocks and was designed by Cuban architects. Five to six thousand men worked in eight hour shifts, day and night, to complete it.

The "Reception Hall," one of the largest on this globe, unique in its beauty and grandeur, is 400 feet long and 45 feet wide, in Italian Renaissance style. Its massive bronze doors of 2½ tons each rest on three ball-bearing hinges. The panels in the three main entrance bronze doors represent important historical Cuban episodes. Thirty-two artistic bronze candelabras give indirect lighting, hidden by the cornice. Decorated in delicate hand painting and finished in 22-carat gold leaf, the ceiling is exquisite as a finished work of art.

After digesting this gorgeous feast at El Capitolio, so exemplifying the love of the Latin races for the exquisite and priceless, we returned to our Hotel Nacional where the genial Dr. and Mrs. Carlos P. Lamar entertained us in their room opposite ours with cocktails and sandwiches.

Then in two large cars our host and hostess guided our jolly party for an evening meal to "El Templete," a sidewalk restaurant located behind the monument commemorating the first Mass said on American soil by Christopher Columbus' chaplain. An order was placed for "Paella Valenciana" at once, since it takes a half hour to prepare this satisfying dish similar to "arroz con pollo" (chicken and yellow rice) to which is added Moro crabs (Cangrejos), lobster, shrimp and two sea fish—all sprinkled with saffron. Our generous doctor ordered and carefully inspected a bottle of fine Amontillado (Spanish sherry wine), some ponies of Italian vermouth ("Cinzanitos") besides a bottle of good Scotch and some soda and, as he orated, "First, relax my friends, relax in the balmy breeze, listen to the songs of the native troubadours over there by the door; enjoy yourselves watching the romantic couples passing by, the rush of cars along the Marine Boulevard (Malecon), the sea-wall, and the moonlight playing lazily on the Gulf beyond." By the time the hydrochloric acid began to gnaw at the lining of our stomachs, the waiter ceremoniously entered with huge platters of "Paella." From then on, as our host predicted, we were too busy eating, oh-ing and ah-ing to recall the anticipating wait.

After that, we turned our noses up at a suggested salad, some fried ripe plantains, a "pudin diplomatico," lightest and tastiest of custards mixed with pieces of fresh fruits, ice creams containing tropical fruit flavors, such as mango or coconut. But we did try a demitasse of the strong and aromatic Cuban coffee, refusing a small goblet of a good Spanish or French brandy, and a good Havana cigar—"to put us at peace with the world."

As we motored en route to the famous "Club Tropicana" through the suburb, Marianao, Dr. Lamar pointed out the place where he was born, less than 300 yards from the entrance gate to Oriental Park race track.

As we entered the big white aristocratic "Club Tropicana" he explained that this was once the home of a wealthy widow who converted the lovely gardens, surrounded by massive trees indigenous to the Cuban soil, into a dancing pavilion or terrace where the best talent of Havana performed.

Dancing under the trees in the tropical moonlight until two a.m. this congenial group of Dr. and Mrs. Carlos Lamar, Dr. and Mrs. Guisseppi (sic) Stewart, Dr. and Mrs. Walter Jones, Dr. and Mrs. Duncan Owens, Dr. and Mrs. Giorgio (sic) Williams, Signora (sic) Tomaso Kreeger and her father, Dr. Guillermo McKibben, retired to the Hotel Nacional agreeing with Booth Tarkington's Penrod Schofield that this had been "some day!"

Most refreshing and delightful of all was Friday afternoon in the country. Dr. and Mrs. George Williams, Darthea and I hired Arturo Sotolongo, "English speaking" driver and his car at Hotel Nacional for a whole day for $15. The morning was devoted to sight-seeing and shopping in the city.

A "number 9" breakfast at the "Miami Restaurant" of orange, grapefruit or pineapple juice, liberal pieces of toast, scrambled eggs and very strong black (as usual) Cuban coffee, and cream, served on spotless linen by a handsome Cuban-Spaniard who understood but did not speak English, all for 80 cents, i.e., the breakfast—not the waiter.

Then to El Encanto, a complete department store much like our Burdine's, where George and I, feeling more or less out of place among so many lustreful eyes, proceeded to buy gifts, such as imported French perfumes.

Then off to the south we four rolled to Rio Cristal Club, once a nunnery, with congenial and talkative Arturo Sotolongo at the wheel—a source of history and unlimited information. The posts

of the fence around the club were painted grotesque colors, but as we drew nearer we caught sight of many hand painted decorations inside and out.

We ordered dinner, then strolled down to the Crystal river to view the dam and waterfalls. The water, crystal clear, flowed smoothly and rapidly past us.

The setting seemed perfect, especially as the polite young Cuban waiter put a large fruit cocktail before us of a combination of half a dozen kinds of tropical fruits, some of which we did not even recognize. Then a salad and red snapper with meat sauce and black beans. There followed a large platter of "arroz con pollo." The curled crackers were unknown to us. The homemade ice cream was flavored with coconut juice and coconut meat, plus one half mixed with ground almonds, with a pineapple marmalade over all—a delicious dessert.

We motored towards the distant mountains, passing hills, clusters of royal palms, the Cuban home of black "Father Divine" who married the pretty young white Nova Scotian and lived in Harlem, thus killing his divinity. Also, goats and good looking milch cows, fat pigs loose in fields, houses with thatched roofs of royal palm fronds, tiny villages with one or two rows of houses, churches, a tobacco plantation, country huts in a Cuban landscape, pineapple fields, royal palm avenues—all these things and much more were seen on our way to the farm where a kindly and congenial host waited on us with cold homemade papaya juice, "Cokos" (the truck from Havana was unloading cases), and souvenirs. We bought cards, books, castinets, gourds, and a huge Cuban-painted drum for Tom at home.

To show how closely the relationships of the new and modern city of Miami and of the historically old yet modern city of Havana were being drawn together, across the dance floor from our table Dr. and Mrs. Lamar were entertaining a large party of their Havana friends.

(It is just such men as Dr. Lamar and such women as Mrs. Edith Clark Stearns, President of the Pan American League, who will soon enable the two adjacent republics to become good neighbors of mutual understanding. It is unfortunate that we do not make the same effort to speak the Spanish language as do our neighbors to the south to speak English.)

At six o'clock we all congregated at the Cuban Woman's Club, called the Lyceum, for cocktails.* A modern building, it boasted a well-stocked library and adjoining was a children's library where

*Here the narrative is continued by Dr. McKibben's daughter, Darthea.

"Capitolio," National Capitol Building, Havana, 1947.

we were surprised to find so many books in English. It was explained that, in English, one can find many more children's stories and fairy tales. The art gallery, large reception room, and dancing terraza were handsome. After a group picture was taken, several of us left for the Hotel Presidente to dine at the terrace cafe, Santa Clara. Some couples, who arrived in Havana later than we, spent the evening making the rounds of the night clubs.

Final Day

On the last morning everyone was up early, some promenading along the Malecon and the Prado by eight o'clock, and many had early breakfasts on the Venetian Pool terrace, taking pictures there and around the cabana pool. One of the most beautiful subjects was the Maine Monument with the rich blue gulf beyond, framed by a group of cabanas on each side, Washingtonian palm tops above and the pool below.

By 11:30, we were all piled, with our luggage, into the lobby, checked out, and were hustled off to the country. There at the Cuban Medical Association's plantation a most unusual and fascinating day followed. In a pavillion of cement flooring and thatched roof, we danced to rumba music, played by a Negro band containing a Chinese Negro, a strange combination. A mulatto girl sang and danced. The wiry maracas manipulator was a frenzied rhythm-maker. The musicians chanted in chorus as they played. There was a constant flow of daiquiris, the principal drink wherever we went. Served with them were fried slices of green plantains, pork rind wafers, and delicious hot meat in light biscuit-buns. Merrily we "floated" to a similar pavillion where we found long tables set for a repast. Here, the orchestra entertained us while we ate tamales and assorted sliced meats, followed by the piece de resistance: arroz con pollo. The Cuban beer, served with the dinner, had a different taste from any found in the States. In costume, the mulatto girl and a Negro boy interpreted a Cuban dance called "The Son" followed by a rumba and the origin of the rumba—a Voodoo dance. The camera fiends took delight in snapping the team, the boy balancing a glass of beer on his head as he had just succeeded in doing during a rhythmic dance.

Dr. Lamar announced the dances with his two adorable children at his feet proudly attentive. He introduced Mr. Mitchell Goberna of Mitchell

Postconvention tourists in Havana, 1947.

The S.S. Florida carried FMA members and guests to Havana in 1936 and 1947. (Courtesy of E. A. Mueller and The Mariners Museum, Newport News, Virginia).

Tours and told of his great cooperation. In turn, Mr. Goberna highly praised the worthy Dr. Lamar for his untiring efforts over a long period of time in carefully preparing all phases of the postconvention tour in Cuba, making several trips to plan the smallest details for our glorious holiday.

Returning to the pavillion, we continued dancing till it was time to leave for the aeropuerto. We hated to leave the gay and memorable fiesta, and certainly we were sad to leave Cuba with its Old World atmosphere and beauty. The finishing touch to our sojourn was a coconut glacé in the airport restaurant—coconut ice cream or sherbert packed hard into half a coconut shell—delicious and refreshing.

*After boarding a plane for Miami my busy thoughts began to run back over two hectic days and nights spent in the Cuban capital. What was the one big thing besides El Capitolio that impressed me most? A perfect stream of things done and things seen rushed through my mind in review:

Music, dancing, eating, drinking, lottery, shouting, chattering, begging, entertaining, horse and dog racing, jai-alai, gambling, shopping, sightseeing, taxis, tips, cock-fights, bull-fights, night clubs, near-nude dancing, courting, cool secluded patios, restaurants and shops wide open to sidewalks and passersby, exotic gardens of rare tropical flowers and plants, of noisy narrow old streets, of interminable busses, grinding electric car wheels, pedestrians passing in and out of old doors, of history and tradition as embodied in old churches, fortifications, castles like Morro, monuments to heroes but none to heroines, the many poor, the rich, too few of the middle class, the luxurious homes of the rum, sugar, tobacco and beer barons, the grotesque shacks of the poverty stricken on the vacant lots of the flats of the great city, the roofs held on by brickbats, the exquisite Vedado homes of the well-to-do, high spiked costly iron fences, arched windows protected by iron bars, cerveza (beer) served in the Tropical Gardens, expensive hostelries with excellent service, speeding common carriers, old community markets, multitudinous fierce-looking Spanish and black policemen to keep the emotional and oft-times uncontrollable mobs in check, the contrasting day and night clubs in the attractive cultured residential and peaceful country sections.

If only the Eastern Hemisphere would take the cue from the Western, and establish a similar good neighbor policy, there would be no World War III.

*Narrative resumed by Dr. McKibben.

Visiting the Medical School and Some Hospitals in Havana

George Williams Jr., M.D.

As was the usual procedure we congregated in the lobby of the hotel about 9:30 a.m., leaving the hotel in small groups. We were taken to the medical school building where we then gathered together and were escorted through the buildings in groups of five or six by English-speaking medical students.

The pamphlets given to us by Dr. Lamar gave a brief history of the school, and the pictures presented a very good idea of the physical set up as we saw it.

The guide for our own particular group was a fifth year student by the name of Castello. He came from another province and was living near the university in an apartment with a brother who was studying law. His tuition was about $80 a year but he had to provide his own room and board. This young student was very proud of the fact that the admittance and progress in school was on a strictly fair competitive basis regardless of color or social status.

From the top of the medical school building we had a good view of the surrounding hospital layout. All about the school were the many small two-story hospital buildings making up the National Hospital Calixto Garcia ("Hospital Universitario"). To the west was a large building, not yet completed, which was to be an orthopedic hospital and near it a relatively new building housing the Cancer Hospital. Across the boulevard, where stood a large monumental piece in memory of General Jose Miguel Gomez, was the hospital for infants and children.

Within the medical school building we saw a very spacious auditorium which could seat the entire student body of about 1,250.

The anatomy laboratory was a most outstanding feature. Here in a large, well-lighted and well-ventilated room was a group of stainless steel dissecting tables with a convenient book support at the head of each table. This was a much finer setup than is found in most of our United States medical schools. There also was a nice room with good equipment for animal surgery.

Some of the other laboratories appeared a little small in size but I suppose they had smaller groups working at one time. We saw only one class in session on this particular Saturday morning, and as the students were just receiving some grades from a pharmacology examination they were obviously not interested in us.

We went through several of the many small two-story hospital buildings which made up most of the hospital proper. Here the ceilings were high with large wards well-lighted and well-ventilated by windows reaching to the ceilings, so characteristic of Cuba. No screens protected the windows and I actually saw a bird fly through a window and out another in one of the wards. Castello told me that Cuba had no poisonous snakes or insects. Visiting one ward for luetic patients we found the darker-skinned ones very willing and anxious to demonstrate their lesions and arsenical dermatitis.

I visited a gallery in one of the surgical pavillions to watch an anastomosis of the portal vein to the inferior vena cava because of portal hypertension from cirrhosis of the liver. Here among the many male students I saw several Cuban girls and a Negress who told me they also were medical students. I found out later that there are quite a few colored students, both male and female, in the medical school.

We visited the Infancy Municipal Hospital which looked more like our best modern United States hospitals than any we visited during the course of the morning. There we saw quite a variety of interesting cases, many of them being a result of nutritional deficiencies.

Our last stop was the Maternity Hospital which was a beautiful building, having ample prepartum and postpartum wards. There was also a ward for infectious and contagious diseases associated with pregnancy. Here in Cuba they seldom ever use obstetrical forceps. If labor was prolonged and interference deemed necessary, a separation of the symphysis pubis was the procedure of

A participant in the postconvention tour (1947) described by Dr. McKibben in the previous article, Dr. Williams takes us to visit certain hospitals and the University of Havana School of Medicine.

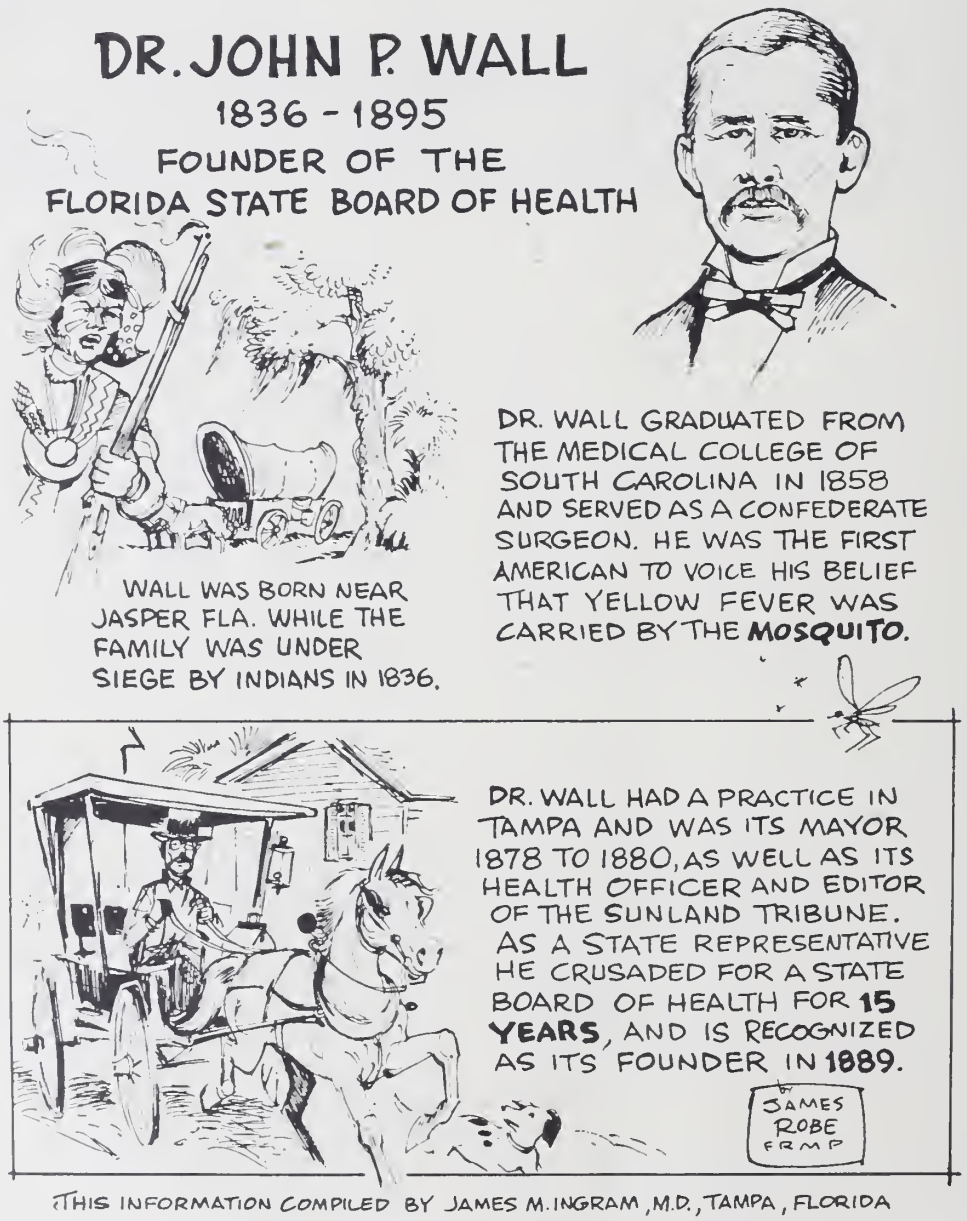
choice, using a small-bladed, long-handled tenotome.

When it was getting close to one o'clock, and many of the group were becoming tired and hungry, we decided to end our tour of the medical center.

About six of us, making up one of the groups, invited three of the students who were serving us as guides to join us for luncheon. They suggested an eating place located in the center of town, so the entire group piled into one of the taxis and off we went. The dining room was very cool and pleasant in spite of the intense midday heat. We had a round of beer and cocktails, followed by delightful Cuban crab with a dessert which somewhat resembled a custard.

This tour was ended at the hotel where we enjoyed a cooling swim in the cabana pool. Truly this had been a very interesting and enjoyable day.

▶ Dr. Williams, 8340 Northeast 2nd Avenue, Miami 33138.



Killer 'Canes and Medical Care

William M. Straight, M.D.

The evening of Friday, September 17, 1926, was an ordinary evening in south Florida as far as Al Buford could tell. He, his wife and two daughters were entertaining Mrs. Buford's relatives from Tennessee. Their house stood on concrete pilings on the edge of the Miami Canal about half way between Hialeah and Pennsuco. Nearby and connected to the house by a boardwalk, passed the Okeechobee Road, built on the fill from the Miami Canal. The garage which served as a shelter for the family cow and the Model T Ford touring car was level with the road and just off it.

The folks sat on the porch enjoying a moonlit evening while the children splashed in water at the foot of the porch steps; the water was unusually high that evening. About nine the wind freshened and the children were sent to bed. About ten the wind and water began to rise rapidly and waves scudded before the wind crashed into the first floor and hammered at the windows as high as the second floor. The house rocked and slid on its pilings and it became evident the house could not long withstand the beating it was receiving.

Instructing the others to dress the children, Al, a powerful six foot four man, waded to the garage, backed the Ford to a spot where it was partially sheltered by the fill embankment, attached a rope to it and made his way back to the house. Securing the end of the line on the porch, and using it to guide himself, one by one he carried the children and helped the adults to the auto. Then he stationed himself outside the car and throughout the night he repeatedly braced his shoulder against the auto body and kept it from being overturned by the wind gusts.

Inside the Ford Aunt Pearl Dowbiggin, a red-haired woman of Irish ancestry, who was never inside a church before or since, prayed loudly, making expansive promises to the Lord to mend her ways. Her brother, a devout lay minister to the mountain people of Tennessee, reminded her of these promises many times in the years to come but Aunt Pearl didn't mend her ways. After a terrifying night a sullen, soggy dawn gradually appeared. The house where the children had played happily but a few hours before was completely gone, only the naked pilings marked its place.

Leaving the family huddled in the auto, Al set out on foot for the nearest neighbor. But this was just the lull and soon the wind began to rise again. He turned around and was literally blown back toward the car. In trying to keep himself erect he pushed his toes right through the ends of his shoes. The second half was more tolerable than the first, for at least there was not the dreaded darkness. Finally, in the late afternoon the wind moderated, Al succeeded in cranking up the Ford, and they slowly chugged to the Hialeah Elementary School. Here the ladies put together a stew made of storm killed chickens. One of the daughters recalls the stew was laced with pin feathers which could not be cleanly removed from the storm-battered fowl. But this was of little moment for people who had eaten nothing for 24 hours. Exhausted, the family wrapped in wet blankets and fell asleep on the floor with hundreds of other refugees.

A Nurses Story

Mrs. Gertrude Rubelli, a Red Cross nurse who lived in Hialeah, gave her account of that same evening. "During the evening of Friday, September 17, the wind began to increase from a light trade wind to a gale of hurricane force. My husband and I came home about ten o'clock and the wind was blowing hard then. At about two a.m. we were awakened by the blowing open of our glassed porch windows, which we then nailed shut, also closing and nailing inside French doors. The house rocked with every blast of wind and at three a.m. the kitchen window was smashed by a broken awning frame, lights went out, and water was shut off.

"At five a.m. the glassed front of our house blew in and at the same time the roof sailed off, landing several blocks away where it was found the next day. We then left the house, fairly crawling over broken dishes, furniture and broken pieces of porch, into a closed car, which was backed to the wind. We took the seat and leaned it against the back window of the car and covered ourselves with a tarpaulin, in case the glass of the car was shattered.

"At about six a.m. the wind began to let up,

and we saw many of our neighbors' homes gone or partially destroyed. Due to the fact that our car would not start, we hailed the first car passing by and asked where they were taking the injured so that I might help. He transported us to the emergency hospital at the (Community) church, going in a very round about way because of poles, trees and houses blocking the streets.

"Upon reaching the church I found Dr. (J. H.) Lamb and Dr. (Leon H.) O'Quinn, our two Hialeah doctors, very busy giving first aid treatment to the injured. There were already about fifteen injured there, and relief workers were bringing them in rapidly. They were placed on chairs, benches, mattresses, and even broken doors were used for stretchers. One man had a big gash across his head; another old man had both legs badly lacerated; a woman was dying from internal injuries. One whole family was brought in: one child dead, one with possible fractured skull, the mother, father and baby with severe lacerations of the body. One man had a big piece of splinter from fallen timber through his cheek and nose, and he sat very patiently while the bigger pieces were pulled out. People with broken legs, arms, ribs, shoulders and lacerations were still coming in for relief and first aid. Three dead children and one young woman, unknown, were brought in. Families were separated, mothers crying for their children. Some had on just night clothes, others were wrapped in wet sheets or blankets, whatever they were able to find as their homes were blowing away. Every car that could run was out scouring the town and vicinity, bringing in injured and dead (and) also people who needed shelter.

"At eight o'clock the storm of wind and rain started again with more fury than ever, and only the ambulance and fire apparatus would hold the road to continue with the rescue work. Houses which had held up in the first storm were swept away in the second and the water was rising rapidly through the upper part of Hialeah.

"The church (The Community Church of Hialeah) was nearly filled with sick, wounded and homeless, between 400 and 500 were already there. The window panes were broken, doors were blown down, and the wind and rain swept through the church. People were huddled together in corners trying to get warm and to keep from being hit by falling glass. All the sick and wounded that possibly could be moved were carried to the altar and choir platform, and were made as comfortable as possible with mattresses, sheets and blankets which nearby neighbors were bringing in from their destroyed homes. Also more dressings and stimulants were brought in by the ambulance.

"The water was rising rapidly inside and outside the church. We had to wade through the water above our knees to get from the front to the back of the church, and people were on top of benches trying to keep out of the water. The church fairly rocked with each blast of wind, the roof was blown partly off, and the walls and plaster were weakening. Outside a car full of people, unable to get inside, saw a part of a roof go over the top of their car and smash another car two feet from them, crushing it almost entirely under water. A man fell down trying to reach the church and three men, tied together, went out and rescued him before he drowned. The church did withstand the storm and at about twelve o'clock the rescue work was continued in full force as the storm had again let up.

"A baby was born in a car in front of the church. The doctor went from there to another confinement and arrived just in time to deliver a

Jackson Memorial was the city's largest hospital, 316 beds.

lovely, fat baby boy. The water being up to the springs of the bed, the family were all moved to drier quarters.

"All Saturday afternoon and evening and Sunday the rescuers continued their work, looking among the ruins (and) finding a few people injured and dead. In their travels they shot and killed seven alligators and several snakes which had come in from the Everglades. . . .

"Patients were taken care of in the church until Sunday afternoon when they were moved to drier quarters in rooms in hotels and apartments that had not blown down. Oil stoves and supplies were brought in and we fed between 700 and 800 each meal. Dry clothing and bedding began to arrive and were given out to all who needed it.

"On Monday the roads had been opened to Miami and all serious cases, about thirty-five in all, were moved to Jackson Memorial Hospital. Fifteen children, some motherless, others just made homeless, were taken in an ambulance to the children's quarters at the White Temple, Miami, (White Temple Northern Methodist Church) and twenty-two dead were taken into Miami."[1]

Hialeah suffered perhaps the greatest destruction in Dade County during the 1926 hurricane. The official tally 12 days after the storm as presented by Dr. J. H. Lamb was 22 dead, 130 severely injured and 1,200 slightly injured.[2] Approximately 200 homes were destroyed. The city's water mains were disrupted in many spots but the storage tanks contained over a million gallons of safe, potable water. The city fathers invited residents to come with containers and help themselves until such time as the mains could be restored and safely used. Perhaps because of these precautions and an active inoculation program against typhoid, no cases of typhoid were reported in Hialeah and only four cases of pneumonia.

In other parts of Greater Miami the destruction, deaths and injuries were also severe. In Coral Gables the Tallman Hospital (Coral Gables Hospital) which had opened in June 1926 and had 30 beds accommodated 100 patients by utilizing beds in the corridors and taking over the nurses residence. In the several days following the storm this hospital admitted 126, treated as outpatients another 400 and recorded eight deaths, four of whom were dead on arrival.[3]

Miami Beach received the brunt of huge waves, rolled up by the wind, that tore at the beach front developments. Rapidly the streets were engulfed in swirling sand and salt water. Buildings, their foundations swept from under them, collapsed and were torn apart by the wind. People drowned in stalled automobiles or were swept out to sea. Power and communication lines were rapidly destroyed, isolating the beach from the town for

On the Beach, the Allison Hospital admitted 200 injured.

many hours. The anemometer on the auxiliary weather station at the Allison Hospital (St. Francis Hospital) blew away registering 128 miles per hour. When the storm finally abated, the Flamingo, Roney Plaza, William Penn and Floridian Hotels were thrown open as emergency hospitals, and the Allison Hospital admitted 200 of the more seriously injured despite the fact that it had no electric power until Thursday, September 23rd.

In Miami proper the sick and injured were taken to one of the following locations: The James M. Jackson Memorial Hospital, Victoria Hospital, Riverview Hospital, McAllister Hotel, and American Legion Home on Biscayne Boulevard.

The Jackson Memorial was the city's largest hospital with 316 beds. When the storm broke there were 220 patients in the hospital. During the ten days after the storm another 250 were admitted of which 12 died, and still another 250 were treated as outpatients. The hospital was severely damaged by the rampaging winds and torrents of rain. Windows were blown out, wetted plaster sagged and fell, two wards had their roofs ripped off and a third partially unroofed, power lines were blown down, plunging the hospital into darkness and making the elevators and x-ray equipment inoperable. The smokestack of the steam plant crashed down on the plant itself, making the sterilizers inoperable. Despite these handicaps the professional staff set bones and sutured and dressed wounds by flashlight and lanterns, often standing in water. Several maternity cases and a clean surgical case were transferred to the nearby Victoria Hospital which had come through the storm with power and a completely functional surgical suite.[4]

Dr. John W. Snyder was appointed Executive Director of the Department of Medical Services and Nurses by the mayor of Miami with headquarters at the McAllister Hotel. He immediately urged all physicians to register for duty at the various emergency hospitals and inaugurated a campaign to inoculate people against typhoid and tetanus. The populace was repeatedly warned to boil all water before using.

The final statistics: 854 injured and 106 dead.[5] At its peak the wind had reached 138 mph, the barometer had dropped to 27.61 inches,[6] an estimated 25,000 had been rendered homeless and damages were estimated between $50 and $500 million.

Inoculation station at the McAllister Hotel.

After devastating the Miami area, the hurricane of September 1926 moved northwest to flatten the long muck dike which had been built in 1922 as a protection for Moore Haven at the south end of Lake Okeechobee. Moore Haven was obliterated and 300 people lost their lives in swirling waters swept from the great lake. However, this was only a token of what was to follow.

The West Indian Hurricane

On the tenth of September 1928, a radio message from a storm tossed freighter, the S.S. Commack, off Barbados gave the first hint of a monster hurricane. At first it was thought not likely that it would strike Florida but by early afternoon on Sunday, September 16, gale winds appeared between Ft. Lauderdale and Ft. Pierce. In the next few hours a killer hurricane moved across the peninsula wreaking widespread death and destruction. With only a few hours warning, Captain E. E. Forbes and others of South Bay drove about the countryside, collected 211 men, women and children and placed them on a big barge in the lake; the barge miraculously rode out the storm and all survived. Dr. William J. Buck of Belle Glade sent trucks to the farming areas of the south end of the lake and brought in all who would leave their homes. Five hundred people were crammed into the two-story Glades Hotel and another 150 into the Belle Glade Hotel across the road. By six p.m. Sunday evening the gale was shrieking so loudly the human voice was obliterated. Out on the lake the water at the north end was rolled up leaving the bottom bare and mounting crests as high as a two-story building which then went scudding south to crash over and destroy the dike protecting the towns of South Bay, Belle Glade, Chosen, Pahokee and Canal Point. An avalanche of water ten feet high, swept through Belle Glade pushing the Belle Glade Hotel from its foundation, but the building held together. Across the road the water rose in the Glades Hotel to within a foot and a half of the first floor ceiling.[7]

At Pahokee O. F. Atkins and family went out in the lull to survey the damage: "About midnite there was a lull and we decided to go down town and see what damage had been done. We found nearly everything gone. Suddenly the wind started again from the opposite direction, and this time it brought the water with it.

"Coming to a deserted house, we broke in. The water came up into the first floor. We went to the second. The water came into that and finally, standing on a table, I managed to break through the plaster into the attic where we all went, cheered only by the pale rays of my flashlight. Then I dropped that into the water and we were in darkness.

"The water steadily rose. It was around our feet in the attic. I tried to break through the roof so we could stand on top if necessary, but had only my bare hands to work with and could not make it. The water was almost to our necks when daylight came and it began to recede. We thought over and over our time had come."[8]

Daybreak on Monday, the 17th, disclosed a vast sea of water filled with debris and the floating bodies of people, horses, cattle, hogs and chickens. As the waters receded and the roads became passable the few surviving injured made their way or were brought to the Glades Hotel where Dr. Buck assisted by Dr. R. M. Daniels did what they could to relieve the suffering. Down at South Bay, Dr. A. L. Shafer, the only other physician between Pahokee and Moore Haven, also treated streams of injured.[9]

The official count was 1,836 dead, untold numbers missing, and $25 million in property damage.[6] The barometer dropped to 27.43 at West Palm Beach, the lowest recorded over the United States up to that time, and the winds were said to have exceeded 100 miles an hour. This disaster led to a federal flood control program for the Okeechobee-Everglades area which includes the present rock levee, 85 miles long, 34 to 38 feet high, along the southeast, south and southwest shores of the lake.

One Doctor's Night of Terror

During the summer of 1935 there were approximately 700 World War I veterans encamped on the Florida Keys. These were the remnants of the "Bonus Expeditionary Force" march on Washington in 1932. Whereas most of the veterans who participated in this demonstration demanding federal assistance for jobless veterans returned to their homes, this group remained in Washington. To get them out of Washington a project was devised and they were employed to build a road from Lower Matecumbe Key to Grassy Key.

These veterans were housed in three wooden barrack camps: Camp #1 at the upper end of Windley Key housing approximately 250 veterans;

Camp #5 at Whale Harbour housing approximately 192 veterans; and Camp #3 on Lower Matecumbe Key housing approximately 241 veterans. About 350 of the veterans had been brought to Miami that Labor Day weekend to enjoy the ball game and other festivities. They had a great time, but their buddies on the keys did not fare as well.

Dr. Lassar Alexander, who practices medicine in Miami today, had taken a job that summer as one of the medical officers for the camps and was stationed at Camp #1. He was quartered in the Snake Creek Hotel which was serving as a hospital for the veterans. When the word of the approaching hurricane was received, since this conch-built wooden building was thought to be the strongest on the island, most of the women and children and many of the veterans gathered there awaiting the train that was being sent to take them to Homestead.

The morning before the hurricane struck, the camp commander had urged Dr. Alexander to pack his Dodge coupe and head for Miami. The young doctor rejected the offer as he wanted to see what a hurricane was like. About eight o'clock that evening he realized he had made a bum decision!

"The storm started in fury at eight p.m. A lot of people were washed away and others left dead after the storm passed. One man I talked with counted eighty dead persons at this camp. Every building was razed and at one time the tide rose entirely over the island.

"I was at the Snake Creek Hotel which was used as a hospital. This building was on the upper end of Windley Key and about a hundred yards from the ocean. As the wind increased it rocked the building and was making so much noise you couldn't make yourself heard even by shouting. Water began to come in on the first floor so I went to my room on the second floor and changed into swimming trunks. Then with my Winchester hunting light I went downstairs and attempted to knock out windows and doors hoping the water would flow through and not destroy the building. I quickly saw this was futile and returned to the second floor just as the building began to break up.

"It was about ten p.m. when the building collapsed with many persons under the ruins. There were about forty people in the building, about half women and children. Out of this number there were only seven men and three or four women and children saved.

"The walls seemed to fold toward the highway and I managed to step from the floor to the now horizontal wall and into the water. It looked deep but my feet rapidly hit bottom and I was standing in perhaps three or four feet of water filled with floating timber and debris. I started for the highway just beyond which was the top of the railroad cut, the highest point on the island. I reached a high bank covered with grass after being pushed by the wind about one hundred fifty yards and being knocked down innumerable times by flying debris. The water would surge around me rising up to my neck then rapidly recede to my ankles. The wind was blowing perhaps one hundred miles an hour. In the beam of my hunting light there appeared what seemed to be a lake.

People huddled together in corners trying to get warm.

Every car that could run was . . . bringing in the injured.

When the daylight came and the water had receded, I realized I had been looking at the railroad cut filled with water. However, at the moment I first saw this, I decided I didn't have the strength to swim, so I lay on the ground along side a large, water-logged, railroad crosstie which was partially anchored in the ground. I locked my arms around it and lay there as the water gradually rose until it was fifteen or more inches deep. I would pull myself up to get my nose and mouth out of water to inhale and then exhale under water. Once or twice I pointed the beam of my light upward and could see two-by-fours going through the air like leaves.

"After perhaps an hour, the water began to recede and I crawled into the now empty railroad cut to spend the rest of the night huddled with a veteran against the side of the cut trying to keep warm. With the light of day I could see my Dodge coupe which had been washed about a hundred yards from its parking spot and the trunk lid had sprung open. I crawled to it and climbed into the trunk where I finally got warm and went to sleep. Some time later several veterans waked me and carried me to the lee of a water-filled tank car standing on a railroad siding. There a fire had been built and some enterprising survivors had managed to make coffee. The sick and injured were comforted as best we could. I was so beaten, abraded, lacerated and sprained I couldn't get on my feet but I did direct others to help where they could. Nearby I could hear sounds suggesting sucking chest wounds coming from two or three of the survivors, but we had nothing to treat them with.

"We remained in the shelter of the tank car all day Tuesday (September 3) for the wind was still blowing hard and it was raining off and on. In the late afternoon the first rescue parties arrived and began ferrying the wounded across Snake Creek in small boats. About eight that night I was taken across the creek and carried in a private automobile to Victoria Hospital in Miami.

"One of those killed at the Snake Creek Hotel was Dr. E. C. Main, Medical Director of the camp, who lost his life as I watched."[10]

This Killer 'Cane (September 2-4, 1935) virtually levelled a ten mile stretch of the Florida Keys. From Tavernier to Key Vaca hardly a man-made structure remained. As daylight came on September 3, the small band of sick, injured and exhausted survivors looked out upon an expanse of desolation. Everywhere the eye could see was a litter of uprooted trees, overturned telephone poles, splintered bits of houses, battered boats and here and there a smashed body protruding from under the debris, floating in an inlet or half buried in the sand. The wind was still high and the rain pelting down. The bridge at Snake Creek was gone and the waters much too swift for rescue craft. The survivors waited in small groups until late afternoon when the wind and seas quieted sufficiently to permit the rescuers to reach them in small boats. Gradually they were ferried across Snake Creek to waiting trucks and ambulances which brought the sick and injured to hospitals in Homestead and Miami.

The extraordinary havoc was wreaked by both wind and water. Giant wind fingers traveling at more than 200 miles an hour pulled off roofs and exploded houses, uprooted trees and telephone poles, and rolled up a monstrous tidal wave. This wave, nearly 20 feet high, rolled past the Alligator Reef Light some time after eight p.m., and soon

thereafter crashed on the hapless keys. A newspaper reporter who rode down on the Florida East Coast relief train that left Homestead after five on the evening of September 2, vividly describes this wave as it hit the train then stopped at Islamorada: "As we neared Islamorada the wind and water increased. The cars swayed on the rails. Most of the twenty-five persons on board were in the two rear coaches. The water was slowing us to a snail's pace. It was dark and we expected momentarily the roadbed would give way.

"Finally, just south of Islamorada, the water forced a stop. (about 8:30 p.m.) It was then well over the rail bed. We had been stopped but ten or fifteen minutes when a wall of water from fifteen to twenty feet high picked up our coaches and swirled them about like straws. We felt them going and I imagine everyone thought it was the end, I know I did.

"We came out of the swirl of water with a thump that tossed the inmates of the coaches across seats, against the windows and in crazy heaps on sidewalls that had suddenly become floors. Miraculously, none was hurt severely.

"The wall of water passed as quickly as it came, else we would all have been drowned like rats in a trap.

"It was daylight before we could determine exactly what had happened. Meanwhile, the wind, which I am certain was more than one hundred miles an hour during the worst of the storm before midnight, hammered at our overturned coaches.

"It was a terrifying night. Our greatest worry was that another tidal wave would come. The wind seemed tame in comparison to the fear of drowning. But outside of the shelter the wind was a killer."[11]

Indeed, the wind was a killer for it hurled uprooted trees and timbers at tremendous speeds that battered those who survived the wave. Charles Van Vechten, not a veteran but a visitor at Camp #1, describes the carnage: "I saw bodies with tree stumps smashed through their chests—heads blown off—twisted arms and legs, torn off by flying timber that cut like big knives."[12]

"The first doctor to get down in a boat to ravaged Camp Five was Dr. G. C. Franklin of Coconut Grove. He found the bodies of 39 men in a windrow, just as the last waves had left them. A man sat against a broken wall with a piece of two-by-four run completely through him, under his ribs, out over the kidneys. He refused the shot of morphine the doctor offered him, before he pulled it out. The man said that when it was pulled out he would die. He asked for two beers, drank them and said, 'Now pull.'

"Dr. Franklin pulled, and he died."[13]

The summing up: One hundred twenty-one veterans and 165 Keys people were killed, virtually all the survivors were injured to some extent, and in all 400 of the approximately 700 people who were known to have been in the path of that storm were known dead or missing. For many years thereafter, from time to time, fishermen and bottle hunters stumbled upon bleached human bones in the remote mangroves of the Keys and the adjacent mainland. The barometric pressure during this killer 'cane dropped to a record low for this hemisphere, 26.35 inches, and the winds, estimated by engineers from the damage done, reached 200 to 250 miles per hour.[6]

Can disasters such as these happen again? It certainly seems likely that hurricanes of this magnitude can come again. Will the toll of lives be as great? Yes, and likely greater. The population density in South Florida and the Keys is much greater than it was 40 and 50 years ago, thus the toll of human life will likely be greater if these monsters return. True we have much better warning systems but will the people heed the warning? True we have a more rigid building code but what human construction can withstand the pounding of tons of water rolled into ten and 20 foot tidal waves by winds up to 250 miles an hour?

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▶ Dr. Straight, 550 Brickell Avenue, Miami 33131.

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Deaths

Angelucci, Helen M., Fort Lauderdale; born 1900; Woman's Medical College of Pennsylvania, 1927; member AMA; died December 11, 1974.

Bevis, William Marion, Lakeland; born 1882; University of Nashville, 1908; member AMA; died October 1, 1973.

Brown, Andrew George, Miami; born 1907; University of Georgia, 1931; member AMA; died February 23, 1975.

Elder, Samuel Fletcher, Coral Gables; born 1894; Tulane University, 1921; member AMA; died August 27, 1971.

Gouchnour, Thomas H., Jacksonville; born 1922; Indiana University, 1951; member AMA; died March 19, 1975.

Groves, Wyatt Hammond, Lincolnton, Georgia; born 1901; University of Georgia, 1924; member AMA, died March 28, 1975.

Lamar, Carlos Perez, Coral Gables; born 1905; Havana Medical School, 1928; member AMA; died February 17, 1975.

Mansfield, George Henry, Venice; born 1913; Western Reserve University, 1943; member AMA; died March 12, 1975.

Marks, Bernard Henry, Miami; born 1928; Washington University, 1955; member AMA; died February 25, 1975.

Martin, Marion Calvin, Plantation; born 1901; Medical College of South Carolina, 1925; member AMA; died February 27, 1975.

Panettiere, Cayetano, Eau Gallie; born 1896; Johns Hopkins Medical School, 1921; member AMA; died March 22, 1975.

Robertson, James Farish, Silver Springs; born 1888; University of Pennsylvania, 1913; member AMA; died April 24, 1975.

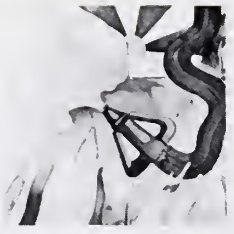
Schmitt, George Frederick Jr., Miami; born 1910; University of Maryland, 1935; member AMA; died February 3, 1975.

Strange, James Lawson, McIntosh; born 1904; University of Georgia, 1927; member AMA; died—date unknown.

Turnley, William Henry, born 1895; University of Virginia, 1924; member AMA; died February 3, 1975.

Warrington, James C., Perrine; born 1908; Boston College of Physicians and Surgeons, 1942; member AMA; died March 10, 1975.

Wynn, John Raymond, Orlando; born 1943; Indiana University, 1968; member AMA; died February 19, 1975.



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Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check **serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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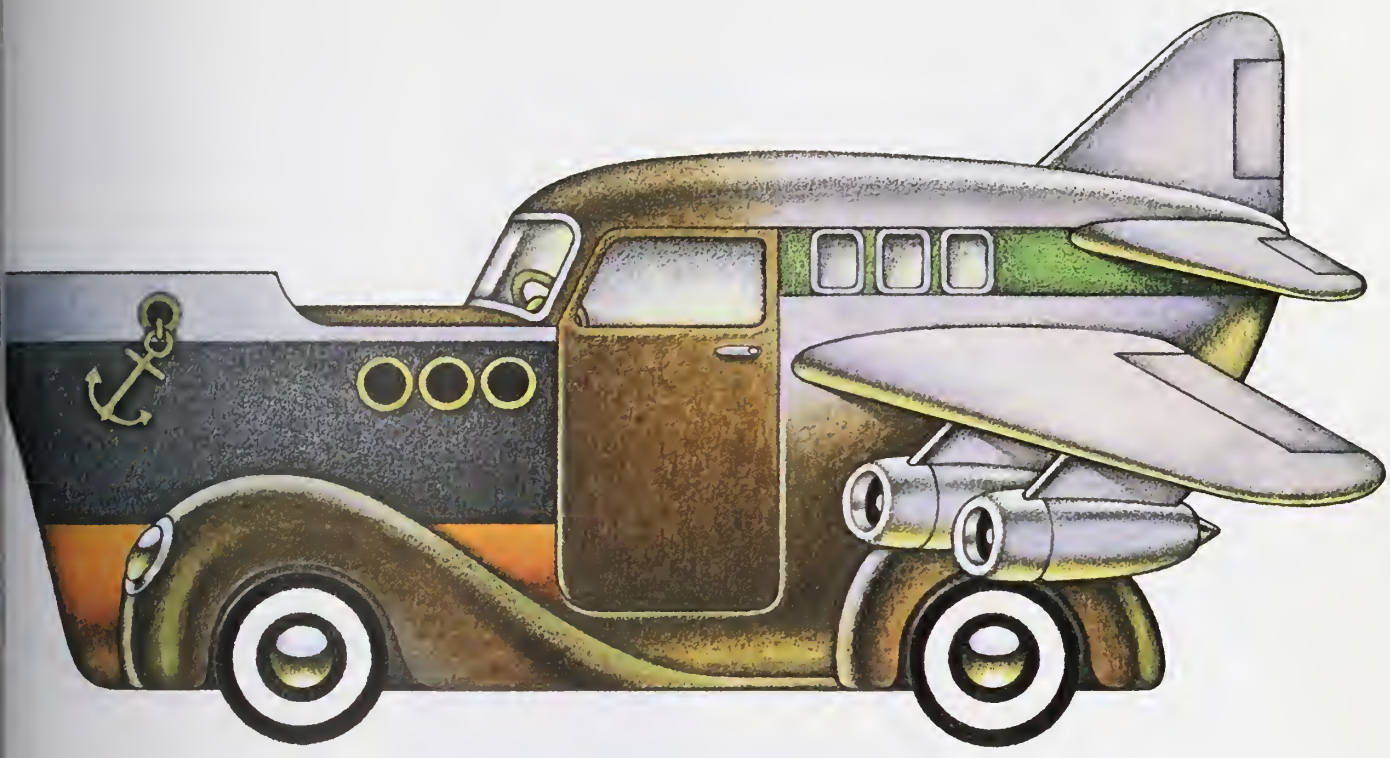

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Antivert®/25 Chewable Tablets
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for motion sickness

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patie
package insert has been around f
a long time. Many physicians alre
use written instruction sheets to
provide patients with information
about the drugs they are taking. A
some physicians give verbal instr
tions; but in too many instances
these are what I call eye-glazing e
ercises. I have seen patients sit w
glazed eyes listening to a rapid-fi
lecture by a hurried physician wh
has 20 people out in his waiting
room. These patients aren't giver
sufficient understanding and the
fore do not follow instructions. Sc
think the idea of an official packa
insert for patients is a good one.
Perhaps we should really think of
this kind of information simply as
extension of drug labeling.

The benefits of patient involveme

Many physicians may not re
ize how frequently a patient obta
his drug information from Aunt
Tillie or the next door neighbor. A
this information is almost alway
bad or irrelevant to the case at ha
Furthermore, the incentive to go
along with a prescribed program
slim if the only reading matter th
patient receives, along with his p
scription, is a bill.

As an educator I am impres
by the principle that the best way
get someone to do something is
involve him in the process. So th

I think there are advantage
well as some real disadvantages
a patient package insert. When y
begin to use semi-medical or me
cal terms to describe complicati
or possible sequelae of disease
treatment, you may frighten the
tient—particularly since the mo
highly sophisticated patient is n
the one who is going to read the
sert. The patient who will read it
the one most susceptible to frig
and confusion by the language.

On the positive side, a pac
insert will probably give the pati
better insight into why he is bei
treated the way he is, and it may
give the physician a little bit mo
time. But it does not remove fro
the physician the need or obliga
to explain the insert.

Some pitfalls in the inclusion of
side effects

Certainly a patient should
warned of the possibility of seri
side reactions—to know what th
real dangers are. But it doesn't
bit of good to indicate that a pa
on oral penicillin may develop a
rash, itching, or a drop in blood
pressure. Or that he may faint.
think the real danger is that frig
engendered by the insert may p
sibly outweigh the potential goo

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

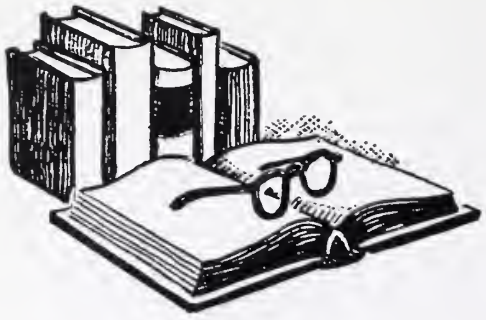
Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Book Reviews

Talking With Patients by Brian Bird, M.D. 2nd ed. 363 pages. Price $10.00. Philadelphia, J. B. Lippincott Company, 1973.

Dr. Bird, Professor of Psychiatry at Case Western Reserve University has revised his book, originally published in 1955. Chapters are brief and written in nontechnical language. Chapter headings include the Anxious Patient, The Anxious Doctor, The Angry Patient, The Patient who Makes the Doctor Angry, The Patient Who Cries, The Dying Patient, Talking About Money and Depression in Surgery.

In his chapter on the Dying Patient, he states "a death in the family, like a birth, like marriage, is a powerful stimulus for many conflicting emotions, few of them new, most of them stirred up from past memories and experiences."

A second section on children is equally well done.

This book can be recommended to students, physicians, and other members of the helping profession. Chapters are brief so that this could be bedside reading material, or a quick reference for physician and/or nurse for use at the office.

Unfortunately, this book may be somewhat similar to the Sunday sermon. Those for whom it was intended and who need it most, will be elsewhere engaged in other activities.

F. Norman Vickers, M.D.
Pensacola

Celebrities on the Couch, Lucy Freeman (editor), Pocket Books, 1971.

One day following a heated argument with a business associate, Arthur E. Meyerhoff, head of the Meyerhoff Advertising Agency in Chicago, talked with Dr. Thomas French, well-known psychoanalyst, about how he could handle the man without jeopardizing his value to the company.

"I think," Dr. French counseled, "that you could benefit from treatment."

"In retrospect," Mr. Meyerhoff states, "while I had believed I was able to function normally in most of my relationships prior to my analysis, I realize now I was incapable of relating intelligently when faced with the temper tantrum of my business associate. I was able to do so only after I understood myself better."

Mr. Meyerhoff is one of 20 well-known persons who recount their experiences with psychotherapy in this candid and fascinating book.

The theme of self-understanding as a prelude to gratifying relationships with other people is taken up by actress Jane Meadows. The perceptive courage that changed her from a fearful, insecure young girl into a mature, competent woman is apparent in her ability to be honest with herself. She had to overcome a family background not at all in sympathy with efforts at self-understanding.

A drama teacher noticed the actress' reluctance to play emotional roles and recommended counseling.

"When he mentioned the subject of psychiatry to me," she recounts, "I responded with alarm, since in the almost Victorian social climate of my childhood a psychiatrist was practically synonymous with an abortionist."

The path to self-discovery for Miss Meadows was not easy. She delightfully describes her first (unsuccessful) encounter with a psychiatrist.

Floyd Patterson, heavyweight champion at 21, began stealing at age eight. A juvenile judge sent him to a special treatment facility for boys in Esopus, N. Y. With patience and great skill, a sensitive teacher eventually was able to break through the barrier and help him.

He refused to participate in class discussions because "I was afraid I'd sound stupid and everybody would laugh."

"You are not stupid," the teacher told him, "and I want you to speak up. Everybody is wrong at times. You don't have to be one hundred per cent right."

This illustrates the point of the book. Whether we are famous or not all of us need human understanding, acceptance, and compassion.

Jose J. Llinas, M.D.
Gainesville

Current Medical Diagnosis and Treatment by Marcus A. Krupp and Milton Chatton. 1,044 Pages. Price $13.50. Los Altos, California, Lange Medical Publications, 1975.

This oversized paperback which appears to have been published annually since 1962, judging from the copyright dates, is completely new to us. In the preface, the authors state "This book is intended to serve the practicing physician as a useful desk reference on widely accepted technics currently available for medical diagnosis and treatment."

Although Krupp and Chatton have authored only four of the thirty-three chapters and co-authored two more, they have enlisted an impressive group of associate authors (32), at least, by academic standing.

The volume runs the gauntlet of the body systems as do most of the other books of this type, but in addition, there is a 26 page chapter devoted to diabetes mellitus, hypoglycemia, and lipid disorders, as well as one on Medical Genetics (something we never have really understood). There is also a very good chapter on Poisons. In it is a special section "Treatment of Less Common Specific Poisonings (Alphabetical Order)" which gives the name of the poison, its manifestations, and treatment. If only for this section, the book deserves a place on the shelf in the Emergency Department.

Overall, the text is practical and specific. What we liked especially was the "General Bibliography" at each section's end, the excellent tables (see Table 6-1 Pulmonary function tests most useful to the clinician or Table 10-5 Uncommon hyperbilirubinemic disorders), and the detailed treatment.

On our particular copy, the publisher was a little sloppy. The last pages which had been glued in came unstuck and started falling out. In addition, someone in the printing department gave us an overdose: we have two portions of pages 53-116.

Although we wouldn't go out each year and buy the latest edition of Current Medical Diagnosis and Treatment, we feel at least one year deserves a place on the generalist's book shelf.

Arthur F. Schiff, M.D.
Miami

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Psychiatry in Primary Care by Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 Pages. Price $12.95. St. Louis, The C. V. Mosby Company, 1974.

Lifesaving, Rescue, and Water Safety by The American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Garden City, New York, Doubleday and Company, Inc., 1974.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company. 1975.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1957.

Human Sexuality in Health and Illness by Nancy Fugate Woods, R.N. with a chapter by James S. Woods Ph.D. 232 Pages. Price $6.95. St. Louis, The C. V. Mosby Company. 1975.

Beneficient Euthanasia edited by Marvin Kohl. 255 Pages. Price $10.95 (hardcover) and $4.95 (paperback). Buffalo, New York, Prometheus Books, 1975.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

How to Beat Fatigue by Linda Pembrook. 223 Pages. Price $6.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1044 Pages. Los Altos, California, Lange Medical Publications, 1975.

Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975

Problem-Directed and Medical Information Systems edited by Marshall F. Driggs, M.D. 241 Pages. Illustrated. Price $15.45. New York, Intercontinental Medical Book Corporation, 1973.

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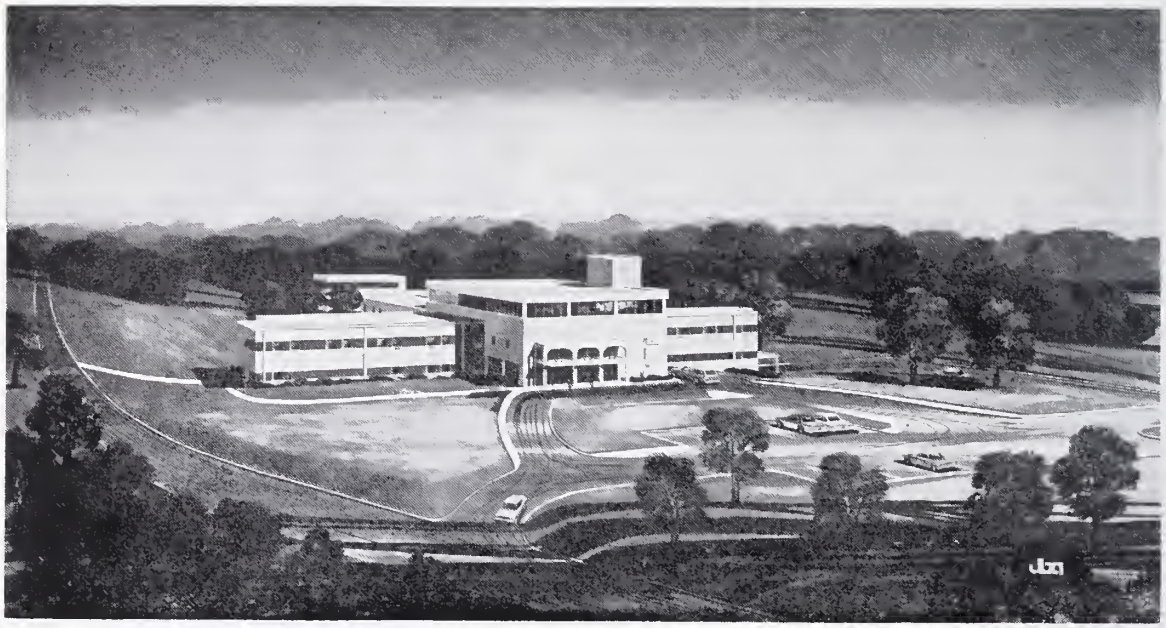

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MIAMI BEACH WILL BE THE SCENE . . . of the American Medical Association's first Winter Scientific Meeting, December 10-13, 1977.

1976 will be the final year for what has been known as the AMA's Clinical Convention. Starting in 1977, the business and scientific sessions of the Clinical Convention will be separated. While scientific sessions are being conducted at Miami Beach, the House of Delegates will meet in Chicago.

WALTER C. WARD, M.D., OF KEY BISCAYNE . . . has been elected to a three-year term on the Board of Governors of the American College of Legal Medicine. A member of the Dade County and Florida Medical Associations, Dr. Ward was engaged in the practice of family medicine prior to entering the practice of law.

SOUTHERN MEDICAL ASSOCIATION . . . has awarded 29 research grants, including three to Florida Physicians. The Florida researchers and their projects are:

A. Jay Block, M.D., Department of Pulmonary Medicine, University of Florida, Gainesville, "Effect of Antioxidants on the Initial Stages of Pulmonary Oxygen Toxicity"; Frederick J. Schoen, M.D., Department of Surgery, University of Miami, "Creation of Synthetic Small Diameter Blood Vessels from Autogenous Fibrous Tissue Capsule Around Synthetic Biomaterials"; and John I. Malone, M.D., Department of Pediatrics, University of South Florida, Tampa, "The Incidence of Diabetic Retinopathy in Children with Diabetes."

A RETIREMENT HEALTH CARE COMMITTEE . . . has been established by the Palm Beach County Medical Society to study the health needs of the elderly and determine how they might be better served. Congressman Paul Rogers praised the Society's action and expressed the hope that it "will result in increased delivery of primary care to our elder citizens."

THE FLORIDA ENDOCRINE SOCIETY . . . has been organized and recognized as a specialty group by the Florida Medical Association. The group plans to present a scientific program at next year's FMA meeting.

FMA members who wish to affiliate with the Society or be placed on its mailing list should contact George P. Heffner, M.D., 4602 N. Federal Highway, Ft. Lauderdale, Fla. 33308.

DR. BUTSCHER HONORED . . . Over 250 people from the communities of Ocala and Gainesville, and the Pediatricians of North Central Florida, honored Dr. and Mrs. William C. Butscher of Ocala on June 12, 1975. Dr. Butscher was cited for his almost two decades of service to the Ocala community and to the pediatric educational programs of the University of Florida College of Medicine.

During the festivities, a new scholarship was announced. The picture above shows Dr. and Mrs. Butscher, together with Dr. H. E. Goodlett, the President of Central Florida Community College in Ocala, renewing the document which sets up the William C. Butscher scholarship in Future Studies, to be given annually to that student best meeting the established criteria. (Photo by David Watson of the Ocala Star-Banner).

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Southern Medical Association 69th Annual Scientific Meeting

Miami Beach, Florida—Hotel Fontainebleau Nov. 16-19, 1975

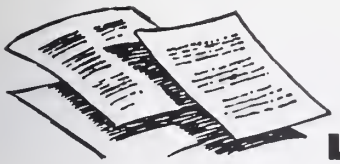
We could draw pretty word pictures about Miami—the scintillating beaches, the glamorous hotels, the superb cuisine, the intriguing spots to visit, the unequaled vacationland—but we won't. You'll have to find out for yourself.

But we will tell you about the most exciting scientific medical meeting of the year – the 69th Annual Scientific Meeting of the Southern Medical Association – featuring a wide range of symposia, 22 sections, live teaching demonstrations, learning center, postgraduate courses, closed-circuit television—something for every specialty.

The Continuing Education Program of the Southern Medical Association has been granted full approval by the American Medical Association's Council of Medical Education.

The best of two worlds is awaiting you.

Make your plans now while reservations are available. Write: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205.



Letters

Frank Hodnette, M.D., Chairman
Committee on Peer Medical Utilization Review
Medical Center Clinic Building
Pensacola, Florida 32501

Dear Dr. Hodnette: I wish to advise you of my resignation from the Peer Medical Utilization Review Committee effective after the meeting preceding the Florida Medical Association Annual Convention. I am advising you at this early time to afford you and President-Elect, Dr. Vern Astler an opportunity to consider replacement. I do not mean to sound presumptious, since I know appointments are on an annual basis. Heretofore, however, reappointment has generally been a formality in the interest of continuity; however, I am not sure at the present time that continuity still remains an asset. There has been a continuous infusion of new members into the committee but there is still a significant number of the original group still present.

I have been a member of this committee since its inception, missing the organizational meeting due to summer vacation. I have since been relatively faithful in my attendance. In view of this, I think I am entitled to make certain observations.

This committee has had probably the greatest impact on the practice of medicine in Florida of any committee since the organization of the state medical association. It has certainly been the center of controversy and has had extremely vocal and strong opponents as well as proponents. Overall, I think the impact of the committee has been of inestimable service in focusing attention on the utilization and economics of the practice of medicine We have stated repeatedly that our aim has been educational rather than punitive and I believe this end has been accomplished. Unfortunately, some of our fellow colleagues have become casualties to the punishment aspect as well as the educational aspect; this has been a regrettable but necessary part of the learning process. From the long hours of bickering, philosophical discussions, endless arguments, has come a set of guidelines which through the years has initiated and perpetuated a steady decrease in hospital over-stays, over utilization of ancillary services, nursing home visits, unnecessary hospitalizations and to a significant degree has undoubtedly tended to slow the increasing cost of Medicare in particular and medical expenses in general. On this accomplishment, I think we are to be congratulated.

However, it has been my impression in the past year to perhaps eighteen months, that the material submitted for review has often times been so near acceptable standards that they, in fact, should not ever have come up for consideration. This can easily be borne out by the increasing percentages of "no problem", by the decreasing percentages of over utilization in those situations which do have a problem, by the diminished number of hours spent at each meeting, and, as a matter of fact, the decreasing frequency of the meetings per se. This has led me to the conclusion that perhaps this committee has outlived, or is about to outlive, its usefulness. I am not suggesting that the committee be dissolved but rather would suggest that it be relegated to a somewhat inactive or watchdog status and perhaps continue as a very knowledgeable observer and critic of medical utilization.

It is my opinion that we should never let the practice of medicine become so restricted by guidelines and norms that we in essence prohibit the development of various and different patterns and modalities of practice. If the practice of medicine becomes so severely stereotyped and restricted then I am firmly convinced that all programs will cease and we will be rightly relegated to the roles of mimics and technicians. There are already far too many rules, regulations, agencies, bureaus, memoranda, guidelines, etc. from external sources that afford adequate input concerning financial and utilization considerations of the practice of medicine. Perhaps as physicians we ought to now begin to seriously reassess the medical aspects of these situations, since we are undoubtedly the only ones thusly concerned; i.e., the best method of patient care and the continuation of medical progress.

This has been a remarkably heterogenous committee composed of right-wingers, left-wingers, specialists, generalists, youngsters, oldsters, representing various areas of the state as well as varying population centers. In this regard it generally reflects the makeup of the Florida Medical Association. I am proud to have been associated with the committee in general and with each member in particular. Like the aging pro-ballplayer, I am retiring before my usefulness and value are outlived and would suggest the committee consider the same option.

Michael J. Foley, M.D.
Melbourne

To the Editor: I have a copy of (a) letter . . . concerning the requirements of Chapter 74-108, relating to prescription drugs. According to this law, every written prescription issued by a practitioner licensed in Florida must include on its face both of the phrases mentioned in the law; namely, "Substitution allowed" and "Prior approval required" and space for the practitioners' initials, if he so desires to initial either of these phrases. In addition, you can have the phrase "no substitution allowed" in capital letters if you wish with space at the end of these three words for your initials to indicate that you absolutely want no substitutions. So your new prescription blank should be printed with both of the phrases required by the law and you may add "no substitution allowed" or you have the prerogative of adding anything else you wish on the face of your printed prescription blank.

George S. Palmer, M.D.
Executive Director
Florida Board of
Medical Examiners
Tallahassee

To the Editor: For the past several years, the Miami Regional Office of the Drug Enforcement Administration has been providing lecturers, training sessions and seminars for a variety of registrants who handle controlled substances.

The Drug Enforcement Administration will provide investigators and/or Special Agents for county, local or state association meetings for presentations regarding the Controlled Substance Act and the regulations promulgated therefor. We will need a minimum of one month notification prior to the presentation date and all inquiries should be made through my office.

If additional information or data is necessary, please correspond with me.

ANTHONY R. ACRI, Supervisor
U.S. Dept. of Justice
Drug Enforcement Administration
8400 N. W. 53rd Street
Miami, Florida 33166

JOSIAH BARTLETT—

The first person to vote for adoption of the Declaration of Independence was Josiah Bartlett of New Hampshire. Born in 1729 in Massachusetts, Bartlett moved to Kingston, New Hampshire in 1750 to practice medicine.

After being chosen by the people as their representative to the Provincial Assembly, Bartlett was also requested to become one of New Hampshire's two delegates to the first Continental Congress. Unfortunately, he couldn't accept this position the first time it was offered because his house was destroyed by a fire thought to have been set by loyalists who objected to his revolutionary activities.

Josiah Bartlett was not only the first person to approve the Declaration of Independence, but first as a delegate to the Continental Congress to sign the Articles of Confederation in 1778. In 1791 he became the first president of the New Hampshire Medical Association, and first governor of the state of New Hampshire in 1793. He was one of a few great Americans who combined the careers of physician, statesman and judge successfully.

As a physician, Bartlett experimented with new ideas, and constantly sought better ways to treat his patients. To relieve severe cases of sore throat he used Peruvian bark long before quinine was extracted from it. His career as a judge began as local justice of the peace and culminated as Chief Justice of the New Hampshire Supreme Court.

Reprinted from Antique Gazette, July 1975.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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Before prescribing, consult package circular or latest PDR information.

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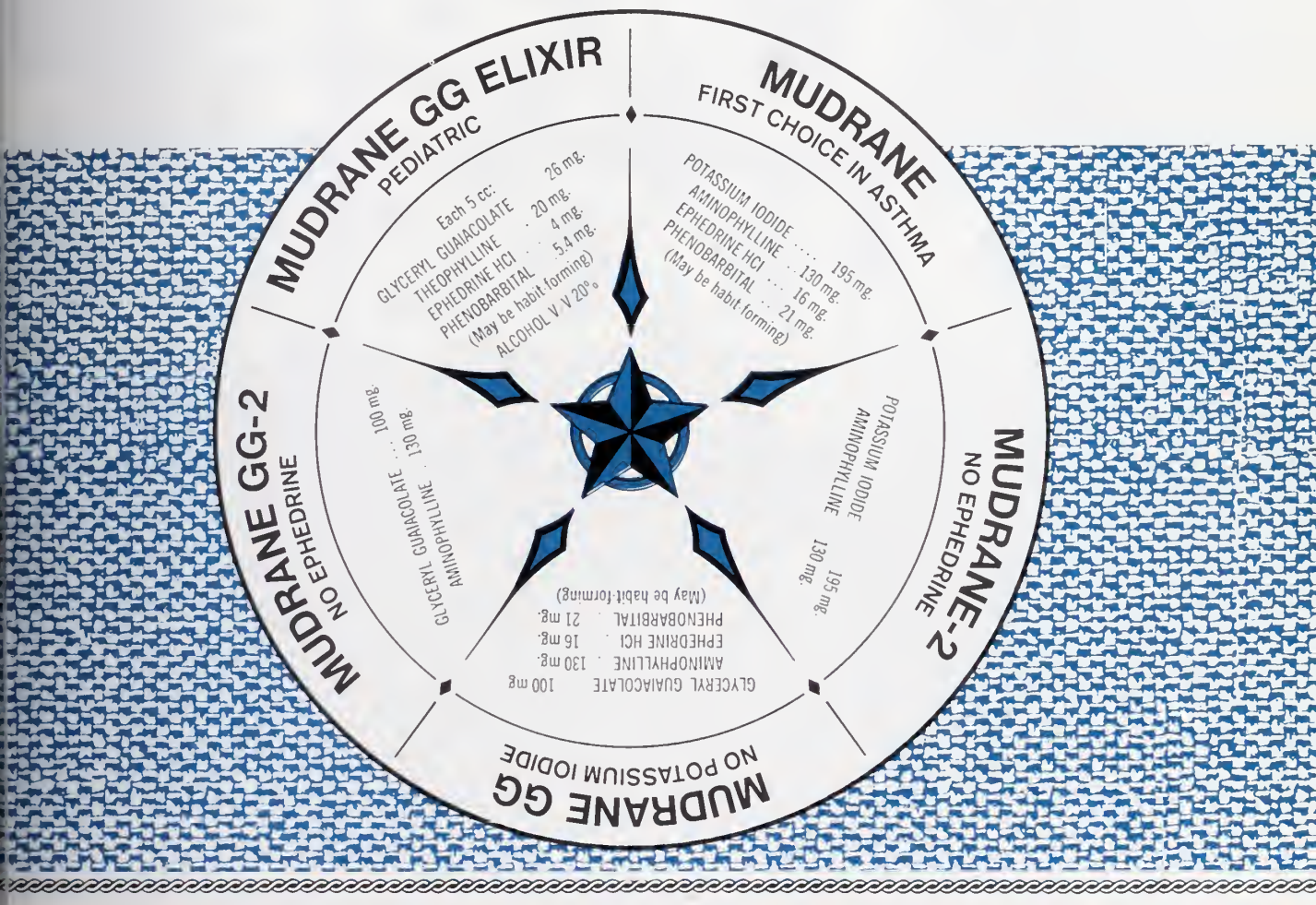

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

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Solar keratoses are generally not difficult to identify.

These skin lesions are usually multiple, flat or slightly elevated, brownish or red in color, papular, dry, rough, adherent and sharply defined. They are found on areas of the skin having extensive exposure to sunlight. Clinical characteristics of the lesions, their predominant location on exposed surfaces, the age of the patient and his skin type are important considerations in the diagnosis.

Solar keratoses can, and should, be treated because they are potentially premalignant.

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Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

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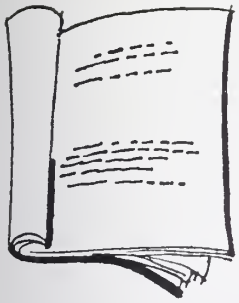

Others Are Saying

Overmanagement of Medicine

The medical profession, which once was the most honored of all, now is under attack from many quarters and exists in what many sense to be an overmanaged condition. In part, this is the fault of the profession itself, which in its preoccupation with patients failed to keep its own house in order. Beyond that, the profession, peculiarly isolated from the political process, failed to apprehend what was going on about it. The consumer of medical services demanded his rights to know a little more. Peer review became a regulatory compulsion, and the presence of non-physicians on review committees became the order of the day. And now the logical extension of peer review, the Professional Standards Review Organization, has come to reality through legislation.

There have been other intrusions. Where once the efficacy of medicines could be established by careful clinical observation, there is a consensus today that this cannot be obtained, or must be suspect. In its place have been substituted placebo-controlled, double-blind, randomized crossover studies. However, in the overweening worship of data that lead to computer printouts for statistical evaluation, there is likely to be loss of the humane aspects of clinical investigation and clinical medicine.

On the other hand, there go unchallenged reports of iatrogenic disorders produced by improper professional use of potent medications. Such reports are neither double-blind nor placebo-controlled; they are not exposed to critical scrutiny. They suffer from fatal defects: lack of standard criteria, lack of careful evaluation, and the curse of extrapolation. Yet they lead to recriminations against the medical profession or indictments of the medicines. Following upon recriminations come regulatory responses.

So restrictive are laws becoming that we see the specter of public reporting of prescriptions and public identification of patients. The result can only be fearful physicians and undermedicated patients. We have begun to see reports of undermedication. For instance, a study by the National Institute of Mental Health in 1971 reported that "if the question is whether physicians are contributing to drug abuse by creating physical dependence among their patients . . . [then our] data indicate that most private practitioners, if anything, err in the conservative direction . . . in terms of the incidence of high levels of psychic distress one could make a good case for the point that population needs for drug treatment are not being met." More recently, there appeared in the *Annals of Internal Medicine* (February 1973) an article entitled "Under-treatment of medical inpatients with narcotic analgesics." The summary of that article indicated that some physicians were likely to exaggerate the dangers of addiction, particularly that of therapeutic origin, and to prescribe lower, sometimes ineffective, doses of drugs, even for patients with terminal malignancy. Beyond that, the National Disease and Therapeutic Index shows that the overall use of sedatives declined by 30 percent in the 7 years ending in 1972, an indication of overrestraint in the use of these types of medication that have a broad usefulness. Production quotas have been established for several scheduled medicines already, and more are being contemplated. Controls, often in conflict with one another, are proposed at state, at national, and at international levels.

If the people are to be well served, physicians must not be shackled and dispassionate discussion must prevail in the promulgation of public policy for medicine. I hope for the day when a great profession, cognizant that the responsibility belongs to it, makes itself heard.—W. Clarke Wescoe, M.D., *Vice Chairman, Sterling Drug Inc., 90 Park Avenue, New York 10016*

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FAMILY PRACTITIONER (AAFP qualified) wanted for north Florida college town. Busy practice in spacious, new two-man office building one half block from hospital. Enjoy getting out of the big city. Contact W. J. Bibb, M.D. (age 43), P.O. Box 179, Madison, Florida 32340. Phone Collect: (904) 973-6561.

WANTED: FAMILY PRACTITIONER ASSOCIATE (Jacksonville area). Immediate opening. Salary open. New clinic office building, modern medical laboratory equipment including x-ray and cardiac stress testing. Write C-676, P.O. Box 2411, Jacksonville, Florida 32203.

MIAMI, FLORIDA: G.P.—Seven man multispecialty, fee-for-service group is seeking a G.P. to join the group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

FAMILY PRACTITIONER to join busy practice in central Florida. New two-man office, two hospitals near by. Fully negotiable terms. Mail curriculum vitae to Stevan M. Van Ore, M.D., 235 Maitland Avenue, Maitland, Florida 32751. Phone: (305) 645-0111.

GENERAL PRACTICE: Prime location in Pompano Beach, Florida. Semi-retired physician interested in office sharing arrangement with another physician. Office fully equipped, including x-ray, 1,500 sq. ft. office. For information call (305) 942-3535 or 941-2420.

ASSOCIATE WANTED: For partnership and eventual take over of adult general practice. Prime location in south Miami for 18 years. Please send curriculum vitae to C-684, P.O. Box 2411, Jacksonville, Florida 32203.

LOCUM TENENS WANTED for all of September. Must have Florida license. Central Florida town, busy general practice. Accommodations furnished, minimum guarantee of $3000. Interview required. George E. Engelhard, M.D., Leesburg, Florida. Phone (904) 787-1600.

FORT LAUDERDALE PHYSICIAN PLANNING RETIREMENT SOON in Holy Cross area. Would like a well trained family physician to occupy adjoining, large, furnished office and gradually take over a busy practice. Must be able to handle upper middle class patients. Give pertinent details in reply. Write C-686, P. O. Box 2411, Jacksonville, Florida 32203.

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INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

OTOLARYNGOLOGIST: Florida space coast area, excellent family living and recreational facilities. Association with early full partnership in growing, incorporated, ENT plus Allergy practice with head and neck, plastics opportunities. Please send complete CV to C-668, P.O. Box 2411, Jacksonville, Florida 32203.

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OBSTETRICIAN/GYNECOLOGIST: Attractive opportunity in north central Florida for private practice. Community has well-equipped, new 128-bed hospital with Ob/Gyn floor. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, P. O. Box 1989, Lake City, Florida 32055. Phone (904) 752-2560.

ORTHOPAEDIC SURGEON—FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

PHYSICIAN WANTED: Two ABIM internists desire internist and cardiologist. Salary leading to partnership. Position available now. Terms negotiable. Write C-688, P. O. Box 2411, Jacksonville, Florida 32203.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

WANTED: GENERAL SURGEON, Board certified; preferably with Gyn training and/or experience; under age 50. Present surgeon disabled, possibly permanently. Opportunity to take over 25 year old surgical practice in 6-9 months. Call (305) 293-9150 or write Alex P. Maybarduk, M.D., 710 East Colonial Drive, Orlando, Florida 32803.

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PHYSICIANS WANTED: G. P. or INTERNIST with or without subspecialty, immediately needed to fill vacancy on southwest Gulf Coast. Office suite available to buy 1,240 sq. ft. Fully equipped, x-ray, dark room, lab., etc. Excellent hospital facility only minutes away. Outstanding opportunity area. Fast growing and in full expansion. Write C-680, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIANS DESIROUS OF RELOCATING: Have immediate openings for all services in all states. "Fee paid." Let us find that position you have been seeking. Contact Recruiting Specialists, Medical Search Division, 3274 Buckeye Road, N.E., Atlanta, Ga. 30341. Phone (404) 939-2580. STRICTLY CONFIDENTIAL.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

EMERGENCY ROOM OPENING: Immediate need for ER group or solo ER physician. New 236-bed hospital on Florida's beautiful Gulf coast. Contact W. E. Wisler, Administrator, General Hospital, 1000 Mar-Walt Drive, Fort Walton Beach, Florida 32548. Phone (904) 242-1111.

WANTED: Emergency room physicians to join newly formed group in Lakeland, Florida. Salary $20/hour, approximate 42 hour week. Contact Stephen Bourgeois, M.D. (813) 689-7623 or Paul Stein, M.D. at 644-1546.

FAMILY PRACTITIONERS, General Internist, Internist-Cardiologist, Internist-Rheumatologist, Internist-Pulmonary Disease and fulltime Emergency Room physicians needed for outstanding practice opportunities. Forty-eight physician medical group, affiliated with 312-bed hospital located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528, telephone (813) 734-6365.

PHYSICIANS, Critical need in the Aberdeen area of the Indian Health Service covering Dakotas, Minnesota and Nebraska. Primary care medicine. Salaries range from $20,000 to $30,000 and generous fringe benefits. NO MALPRACTICE INSURANCE. Contact Physician Recruiter, Aberdeen Area Indian Health Service, Federal Building, Aberdeen, South Dakota 57401. Call (605) 225-0250, Ext. 451.

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GATEWAY HOSPITAL — Florida's newest hospital in St. Petersburg, 301-bed now under construction, completion December 1975. 48,000 sq. ft. office space available December 1975 adjacent to hospital. ALL TYPES PHYSICIANS NEEDED. For further information contact Bernard L. Samson, Gateway Hospital Corp., 2600-9th St., N., St. Petersburg, Florida 33704. Phone (813) 822-8716.

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Tavares, Florida (Lake County Health Department) COUNTY HEALTH DIRECTOR II: Salary from $27,498.96 depending on qualifications. Lake County is seeking an experienced, capable individual to head its Health Department. The individual sought must have the following qualifications: Graduation from an approved school of medicine, a masters degree in public health and one year of responsible administration public health experience; or graduation from an approved school of medicine and two years of progressively responsible administrative experience in public health; or a certification by the American Board of Medicine. A necessary special requirement is a license to practice medicine in the State of Florida. The individual will be responsible for the administration of a department of twenty-five to thirty employees. Submit resume to: James C. Watkins, Clerk, Board of County Commissioners, P. O. Box 297, Tavares, Florida 32778 or call (904) 343-5152—Extension 17.

situations wanted

INTERNIST-GASTROENTEROLOGIST, 36 years old, board eligible, University trained in all aspects of diagnostic gastroenterology, actively in practice in Florida for the last two years, prefer solo practice. Write C-687, P. O. Box 2411, Jacksonville, Florida 32203.

CANADIAN PRACTITIONER, age 38, wishes to relocate to Florida, seeks house physician position. Further information on request. Write 7925 Kingsley Road, Apt. 1401, Montreal, Quebec, Canada.

INTERNIST, 36, ABIM eligible, wants to buy practice or join physician ready to retire. Also will consider partnership or group practice. Write P.O. Box 341, Hasbrouck Hts., New Jersey 07604.

RADIOLOGIST—routine diagnosis. Mature, certified, Florida licensed, seeks moderate volume, full time position at negotiable salary. Office, clinic or hospital; prefer southern part of state. No future partnership requirements. Call (212) 249-7044 Collect.

PEDIATRICIAN, Board eligible, 29, married, two children, U.S. trained, Bilingual (Spanish and English), holds Florida license, seeks to join a group or solo-pediatrician in need of a partner. Prefer Central or South Florida. Write Alfredo Cartaya, M.D., 5760 Adelyn Road, Pensacola, Florida 32504. Home phone: (904) 476-6837. Available July 1, 1975.

POSITION WANTED: Board certified Internist, age 32, subspecialty infectious diseases. Seeking hospital-based or large group practice. Available July 1976. Write C-689, P.O. Box 2411, Jacksonville, Florida 32203.

real estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

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PALM BEACH—1,200 square feet medical office plus five (5) rental apartments. Ideal for two primary physicians, preferably board certified Internists. Start on net lease basis with option to purchase. Write C-675, P.O. Box 2411, Jacksonville, Florida 32203.

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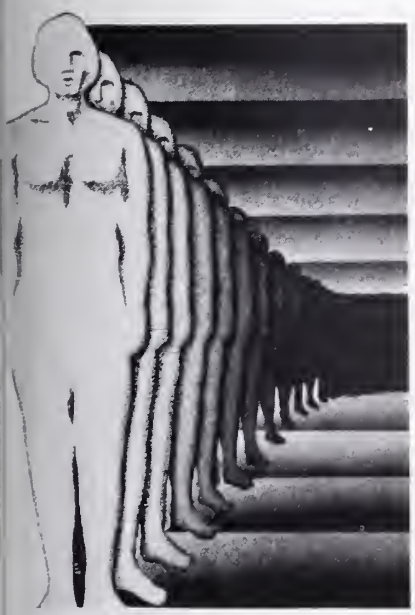

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
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Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

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Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital
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eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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SEPTEMBER COVER — The cover was drawn by Dr. John W. Snow, Jacksonville, the second in a series of creative cover pictures by Dr. Snow for The Journal, highlighting the lead article.

President's Page

Guaranteed Results

Untold numbers of professionals have devoted countless manhours to the present professional liability crisis and to its possible solutions. Much of this thought and material has now been hashed and re-hashed with very little new or original thought in recent weeks. This state of affairs has caused me to reflect upon certain social, economic, and philosophical thoughts which I should like to share with you.

At the time of the Bicentennial of our country, I have cause to wonder just how our founding fathers would react were they to review the current interpretation of our Constitution by Equalitarians and Social Planners. The phrase "all men are created equal" originally seemed to mean that men, by their nature, possess equal and inalienable right to life, liberty, property, and the pursuit of happiness. These now have spread over our country into a trend to equate rights with opportunities (and indeed material things and pleasures), so we come to the confusion of equality with equal opportunity and equal blessings. I submit that men such as Jefferson and Lincoln never intended to dictate equality of condition.

The obvious conclusion would seem to be that the opportunities of one man can extend no farther than where the rights of another man begin. It was Lincoln who said, "You cannot strengthen the weak by tearing down the strong."

The liability crisis must relate in no small measure to the permissiveness of our society, the welfare syndrome, and the diminished demand for individual responsibility. The attitude seems to prevail that nothing should go wrong in life, but if it does, all reverses should be handsomely compensated materially. This is not to say that compensation should not be available for patients harmed through carelessness or negligence on the part of their physician—it *is* to say that many "malpractice suits" are a psychological spin-off of the welfare system. In this "age of meliorism" results deemed satisfactory 10 or 15 years ago are not considered so today. Each patient seeking medical or surgical services is already suffering from some injury, illness, deformity, or disability. Under these circumstances, the best result any professional can achieve is substantial improvement in the patient's condition. Under optimum circumstances the patient ends up with some (hopefully small) deficit. Even if cured of his illness or successfully treated of his injury, the result leaves him somewhat less sound than if he had never been sick or injured. Accordingly, any patient may be dissatisfied and therefore becomes a potential claimant.

All of the foregoing is a way of saying that in addition to legislative relief, our public must realize that high verdicts and settlements are paid with their dollars. Perhaps a sincere return on the part of physicians, attorneys, and the consumer to some American values of professional restraint, thrift, self-reliance, and individual accountability could prove most rewarding.

Vernon B. Astler

When sequential contraception is preferred...

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Ortho-Novum SQ provides good cycle control

provides a low sequential dosage

effective in clinical trials, with a pregnancy rate of 0.43 per 100 woman years

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available in the unique DIALPAK* Tablet Dispenser

Ortho-Novum SQ

TRADEMARK

Each white tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See prescribing information on following page.

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OJ 622-5

In sequence...

Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SQ Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0.08 mg, and blue tablets containing both mestranol 0.08 mg and norethindrone 2.0 mg.

Action: Gonadotrophin suppression.

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy. Liver disease has also been reported, and the physician should be alert to its earliest manifestations.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication: Contraception.

Contraindications: 1. Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions. 2. Markedly impaired liver function. 3. Known or suspected carcinoma of the breast. 4. Known or suspected estrogen-dependent neoplasia. 5. Undiagnosed abnormal genital bleeding. 6. Known or suspected pregnancy.

Wernings: 1. The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis. Should any of these occur or be suspected, the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives. There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country.[4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4.4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users.

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group. This study in its interim analysis states: "A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk." The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users. The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations.

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment.

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4.1 to 9.5 times greater in users than in non-users. A comparable estimate for hemorrhagic stroke was 2.0.

None of the American studies was designed to evaluate a difference between products. However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products.

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users. It has been recommended that therapy be discontinued at least one month prior to elective surgery.

2. Discontinue oral contraceptive medication if there is gradual or sudden partial or complete loss of vision; proptosis or diplopia; onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe; papilledema; or any evidence of retinal vascular lesions.

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy.[11,12] The safety of ORTHO-NOVUM SQ in pregnancy has not been demonstrated. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

5. Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed before prescribing oral contraceptives and periodically during their administration and should include special reference to breasts and pelvic organs, including Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. 2. Endocrine and possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ. Therefore, if such tests are abnormal in a patient taking ORTHO-NOVUM SQ, it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated. 6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 7. Any possible influence of prolonged ORTHO-NOVUM SQ therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORTHO-NOVUM SQ therapy. 9. The age of the patient constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ may mask the onset of the climacteric. 10. The pathologist should be advised of ORTHO-NOVUM SQ therapy when relevant specimens are submitted. 11. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids. 12. Cholestatic jaundice has been reported in users of oral contraceptives. If this occurs, ORTHO-NOVUM SQ should be discontinued. This condition is more likely to occur in patients who have experienced cholestatic jaundice of pregnancy. Patients with a history of cholestatic jaundice of pregnancy should be carefully observed during ORTHO-NOVUM SQ therapy.

Adverse reactions observed in patients receiving oral contraceptives: A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism, cerebral thrombosis and hemorrhage, gallbladder disease.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis; hepatic lesions with or without intra-abdominal bleeding.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, rash (allergic), mental depression, change in weight (increase or decrease), breast changes (tenderness, enlargement and secretion), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, rise in blood pressure in susceptible individuals.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post-treatment, which tends to occur more frequently in women with a history of menstrual disorders, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, intolerance to contact lenses, nervousness, dizziness, fatigue; backache, hirsutism, loss of scalp hair; erythema multiforme, erythema nodosum, hemorrhagic eruptions, itching, vaginitis.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function—increased sulfobromophthalein retention and other tests, coagulation tests—increase in prothrombin, Factors VII, VIII, IX and X, decrease in anti-thrombin III; increase in platelet aggregability; thyroid function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease. J Coll Gen Pract *13*:267-279, May 1967. **2.** Inman, W.H.W.; Vessey, M.P.: Investigation of Deaths from Pulmonary, Coronary and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Br Med J *2*:193-199, April 27, 1968. **3.** Vessey, M.P.; Doll, R.: Investigation of Relation between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Br Med J *2*:651-657, June 14, 1969. **4.** Sartwell, P.E.; Masi, A.T.; Arthes, F.G.; Greene, G.R.; Smith, H.E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Am J Epidemiol *90*:365-380, Nov. 1969. **5.** Oral Contraception and Increased Risk of Cerebral Ischemia or Thrombosis, N Engl J Med *288* (17):871-878, April 26, 1973. **6.** Oral Contraceptives and Stroke in Young Women. Associated Risk Factors, J A M A *231* (7):718-722, Feb. 17, 1975. **7.** Oral Contraceptives and Venous Thromboembolic Disease, Surgically Confirmed Gall-Bladder Disease, and Breast Tumours. Report from the Boston Collaborative Drug Surveillance Programme, Lancet: 1399-1404, June 23, 1973. **8.** Royal College of General Practitioners: Oral Contraceptives and Health, 1-100, May 1974. **9.** Vessey, M.P., Doll, R.; Fairbairn, A.S., Glober, G.: Postoperative Thromboembolism and the Use of Oral Contraceptives, Br Med J *3*:123-126, July 18, 1970. **10.** Greene, G.R.; Sartwell, P.E.: Oral Contraceptive Use in Patients with Thromboembolism Following Surgery, Trauma, or Infection, Am J Public Health *62*(5):680-685, May 1972. **11.** Nora, J.J.; Nora, A.H.: Birth Defects and Oral Contraceptives, Lancet: 941-942, April 28, 1973. **12.** Janerich, D.T.; Piper, J.M.; Glebatis, D.M.: Oral Contraceptives and Congenital Limb-Reduction Defects, N Engl J Med *291*(14):697-700, Oct. 3, 1974.

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INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

SEPTEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 8-13, Jackson Memorial Hospital, Miami*

Florida Society of Anesthesiologists Annual Fall Meeting: Current Status of Inhalation Anesthetics, Sept. 13, Walt Disney World, Orlando. For information: Edwin S. Munson, M.D., Dept. of Anesthesiology, University of Florida, Box 721, J. Hillis Miller Health Center, Gainesville 32610

Teaching Conference in Pediatric Radiology, Sept. 17-21, Miami*

Tumor Immunology and Immunotherapy, Sept. 18, Mr. John's Steak House, Inverness*

Hand Surgery, Sept. 19-21, Miami*

Fall Meeting of the Florida Allergy Society, Sept. 19-21, Innisbrook Resort and Golf Club**

Facts and Fantasies About Diverticular Disease of the Colon, Sept. 24, Sacred Heart Hospital, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Second Annual Cardiovascular Symposium, Sept. 25-27, The Hilton Inn, Gainesville. For information: Howard W. Ramsey, M.D., P.O. Box 13494, Gainesville 32604.

Gastroenterology Today: for the Clinician, Sept. 26-28, Innisbrook Golf and Resort, Tarpon Springs**

Courses in Instruction in Coronary Care for the Practicing Physician, Sept. 29-Oct. 4, Jackson Memorial Hospital, Miami*

OCTOBER

Infection Control Practice—1975, Oct. 2-3, Cedars of Lebanon Health Care Center, Miami. For information: Thelma MacGregor, 1321 N.E. 14 St., Miami 33125.

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33205

Internal Medicine for the Practicing Physician, Oct. 3-4, Perdido Country Club, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Review Course on "Fundamental and Clinical Aspects of Internal Medicine," Oct. 5-18, Key Biscayne Hotel, Key Biscayne (Miami)*

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Symposium on Emergency Cardiology and Medical Services, Oct. 12-14, Orlando Hyatt House, Orlando**

Arthritis and Orthopaedics, Oct. 17-19, University of Miami, Miami*

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel & Tennis Club, Key Biscayne*

Florida Society of Internal Medicine and the American College of Physicians Regional Meeting, Oct. 31-Nov. 2, Innisbrook Resort, Tarpon Springs. For information: James A. Winslow Jr., M.D., 1 Davis Blvd., Tampa 33606

NOVEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Nov. 3-8, Jackson Memorial Hospital, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 14-15, Americana Hotel, Bal Harbour*

▶Southern Medical Association, Nov. 16-19, Fontainebleau Hotel, Miami Beach. For information: Mr. Robert F. Butts, 2601 Highland Ave., Birmingham, Alabama 35205

▶American Fracture Association, Nov. 16-20, Americana Hotel, Miami Beach. For information: H. W. Wellmerling, M.D., 600 Livingston Bldg., Bloomington, Illinois 61701

Human Union: The Health Practitioner Looks at Sexuality, Nov. 20-23, Americana Hotel, Bal Harbour*

Second Annual Miami International Conference — Progress and Prospects in Health Care Distribution Systems, Nov. 23-26, Americana Hotel, Miami Beach*

DECEMBER

Florida Society of Ophthalmology Fall Meeting, Dec. 4-7, Innisbrook Resort and Golf Club, Tarpon Springs. For information: Susan Waits, Suite 346, Barnett Bank Bldg., Tallahassee 32301.

Courses in Instruction in Coronary Care for the Practicing Physician, Dec. 8-13, Jackson Memorial Hospital, Miami*

Non-Invasive Methods of Cardiovascular Diagnosis & Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Heart Association of Broward County, 440 N. Andrews Ave., Ft. Lauderdale 33301

JANUARY

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 5-9, Miami*

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Emergency Cardiac Care: 1976, Jan. 15-18, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33136

Current Concepts in Rheumatology, Jan. 23-24, Sonesta Beach Hotel, Key Biscayne. For information: Roy Altman, M.D., V.A. Hospital, Dept. of Medicine, Miami

Pathology Symposium: Review and Recent Practical Advances, Jan. 20-23, Deauville Hotel, Miami Beach*

Anatomic Pathology Seminar, Jan. 23-26, Deauville Hotel, Miami Beach*

Miami Winter Symposia—Biochemistry, Jan. 1976, Miami*(Dates to be announced)

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Eleventh Annual Postgraduate Course in Internal Medicine, Jan. 25-30, Hotel Fontainebleau*

Twenty-First Central Florida Medical Meeting, Jan. 28-Feb. 1, Orlando. For information: Howard E. Gross, M.D., 15 W. Columbia St., Orlando 32806

FEBRUARY

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

MARCH

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Miami*

Sixth Annual Special Procedures Seminar "Why and How to do Special Procedures," Mar. 21-24, Hyatt House, Miami Beach*

Clinical Radiology Seminar, Mar. 23-27, Miami*

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

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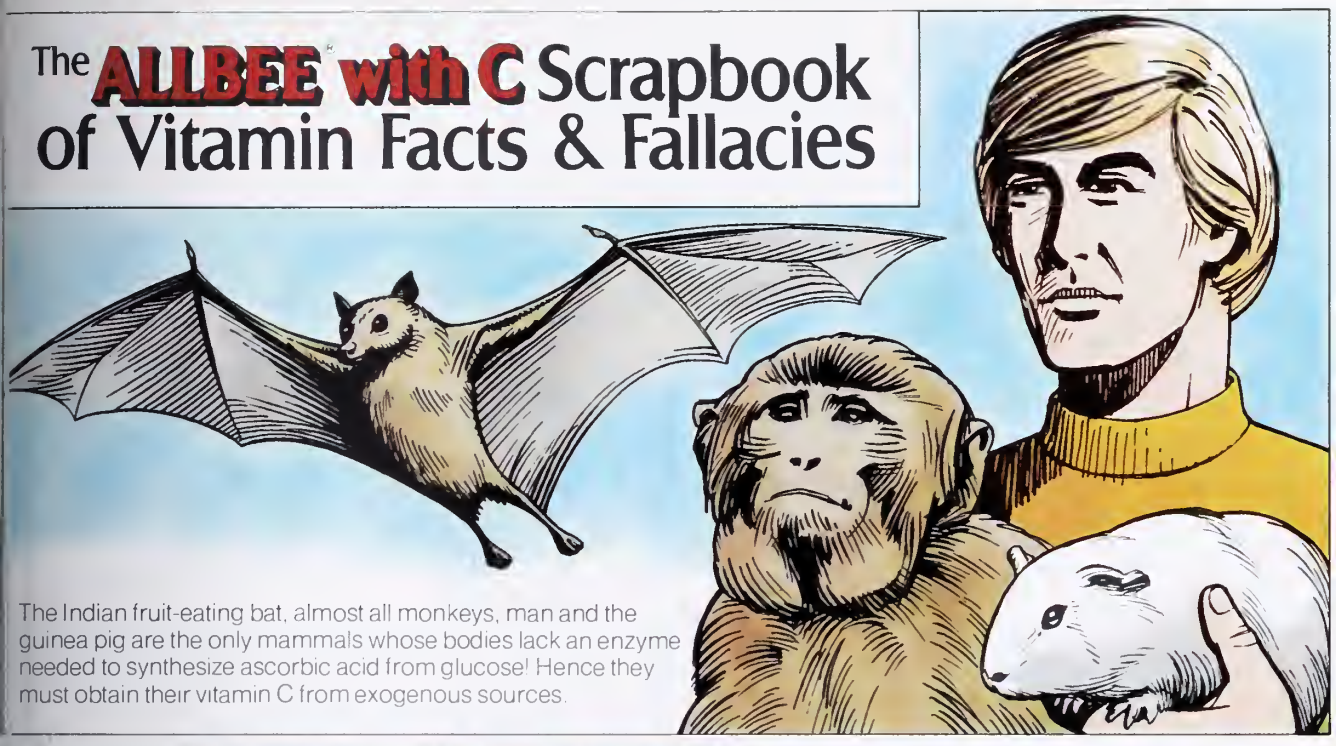
*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box 758, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

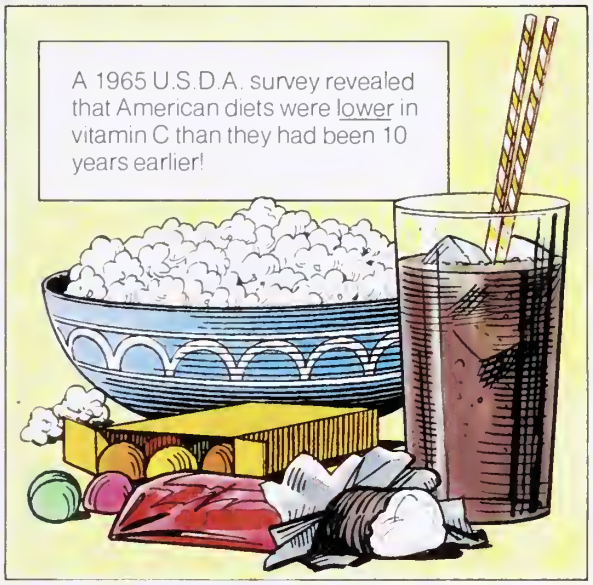
▶ National meetings being held in Florida.

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

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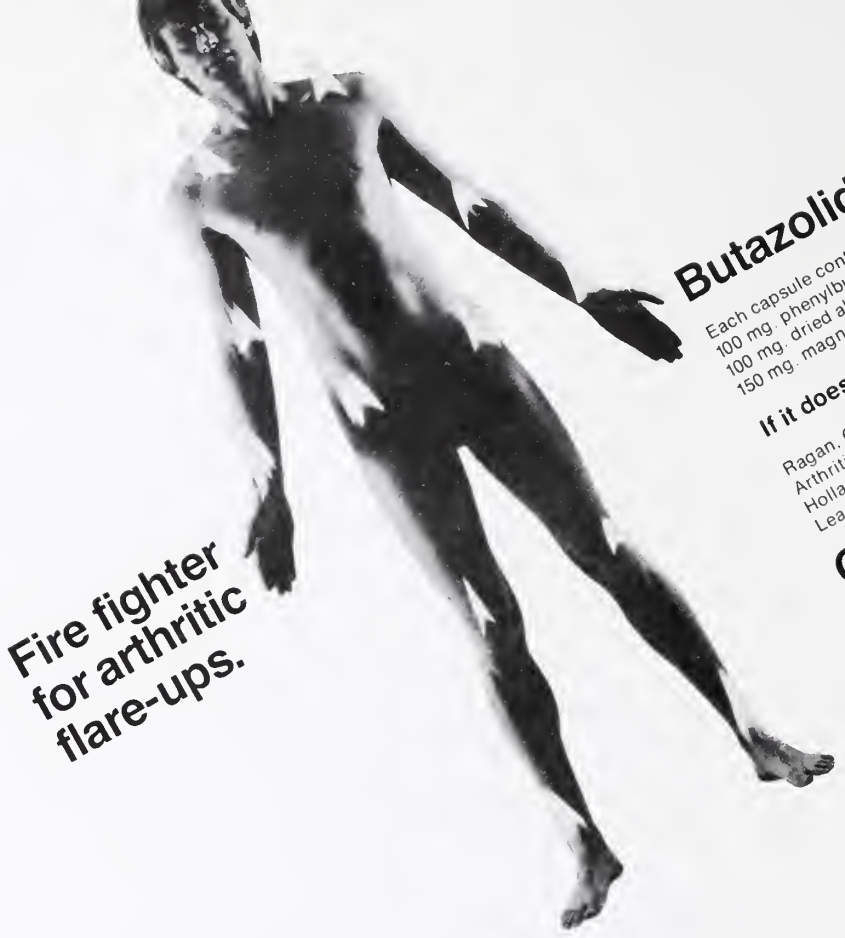

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

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Niacinamide	100.0 mg.
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg.
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg.
Cyanocobalamin (Vit. B_{12})	5.0 mcg.

Each tablet contains 0.15 mg. saccharin as sodium saccharin.

Each tablet provides the following multiples of the recognized adult minimum daily requirements:

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Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established.

USUAL DOSAGE: *Adults*—1 tablet daily, or as directed.

SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100.

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
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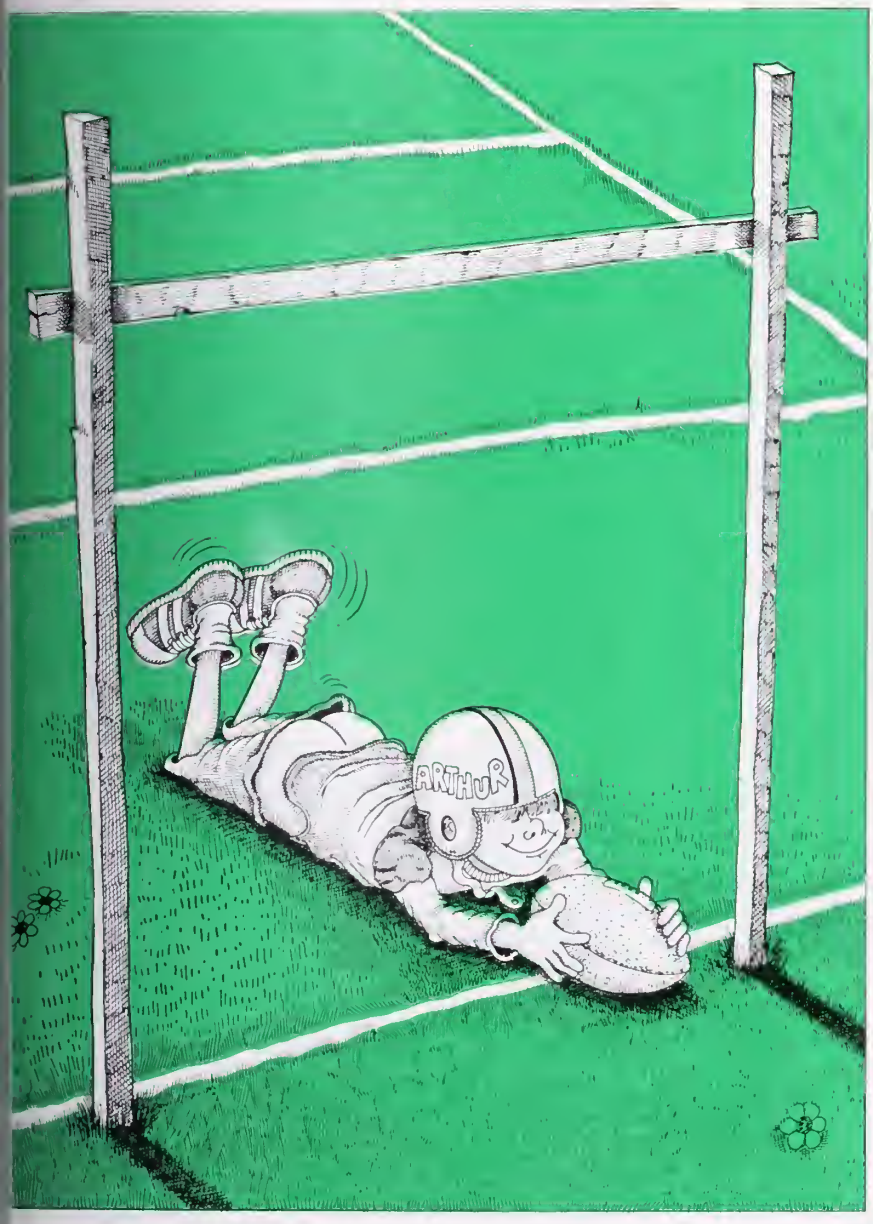

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Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

SEPTEMBER, 1975 • VOLUME 62 • NUMBER 9

Flexion Contractures of the Hand

JOHN W. SNOW, M.D., ROBERT O. POHL, M.D., AND LEWIS J. OBI, M.D.

Abstract: Flexion contractures of the hand are often encountered and their surgical correction is predicated upon a thorough understanding not only of the initial cause of the contracture, but of the secondary changes in related structures which must also be dealt with efficiently for satisfactory results. These changes plus methods of surgical correction are discussed.

Flexion contractures of the hand are encountered frequently and the operative maneuvering sometimes necessary to adequately correct them is relatively complex. These are the reasons for this presentation which may be helpful to surgeons and broaden the general understanding of the family practitioner.

There are many initiating causes of flexion contractures, both primary and secondary. Whatever they may be if the contracture is of several months duration virtually all associated structures may have become shortened. It is therefore courting disaster to approach a scar contracture on the volar surface of a digit with the thought that simple skin replacement will correct it when correction of associated structures such as the flexor sheath, volar plate, collateral ligaments and extensor mechanism, may be necessary.[3,4,5,6,8]

PRIMARY FLEXION CONTRACTURES.—Many soft tissue structures located volar to the midaxial line of the palm and fingers are capable of shortening and producing a primary flexion contracture. This most commonly is the skin, but may be the palmar fascia, flexor tendon sheath, flexor tendons, neurovascular bundles, volar plate, or volar half of the collateral ligaments of the interphalangeal joints. Examining each of these structures and noting their interrelationships seems appropriate.

SKIN.—Longitudinal lacerations across flexion creases of the fingers often shorten and produce contractures. These linear bowstring type restricting scars can often be corrected by one or two Z-plasties to add the additional length necessary. Usually a 60° Z-plasty works well. We prefer, in the adult, a ¾″ Z, and make several if necessary. Full passive extension may require that a window of the flexor tendon sheath be removed if this has shortened due to a prolonged flexed position. It appears that the membranous portion of the flexor tendon sheath accordions in and out with flexion and extension of the fingers (Fig. 1). When held in a prolonged flexed position, shortening occurs in this portion of the sheath.[9] If the digit still cannot be passively straightened the volar plate may have become incarcerated in the volar plate recess and needs to be freed (Fig. 2). If the proximal interphalangeal joint still does not straighten, the volar half of the collateral ligaments should be excised bilaterally (Fig. 2). These are slightly volar to the axis of rotation of the proximal interphalangeal joint and under persistent flexion tend to shorten and limit subsequent extension.[4,5,6] (The opposite is true if fixed in extension). The remaining dorsal portion of the collateral ligaments maintains lateral stability of the joint. If

From the Department of Orthopedic Surgery, University Hospital, Jacksonville, Florida.

Fig. 1.—Membranous portion of flexor tendon sheath excised. Flexor and extensor tendons and sheath painted with lead-based paint and x-rayed. Note pulley over midportion of the middle phalanx in flexion is closer to pulley over proximal phalanx, thereby necessitating telescoping of normally present membranous portion of the pulley mechanism.

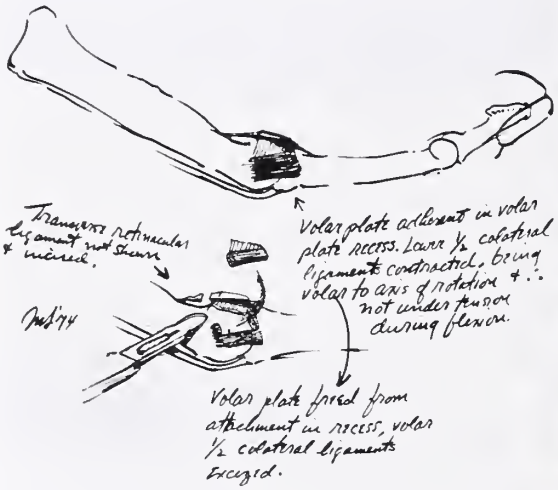

Fig. 2.—Volar plate adherent in the volar plate recess. Lower half collateral ligaments contracted, being volar to axis of rotation and therefore not under tension during flexion. Volar plate freed from attachment in recess, volar half collateral ligaments excised. Transverse retinacular ligament not shown and incised (after J. Wm. Littler).

Fig. 3A.—Burn contracture with long, ring, and little fingers adherent to palm and to each other.

Fig. 3B.—Contracture incised so that digits may be straightened. Note excision of flexor tendon sheath over proximal phalanx of ring and little fingers.

Fig. 3C.—Flap from dosal aspect of ring and little fingers brought volarly to cover the exposed flexor tendons of ring and little fingers; thick (20/1000") graft used to resurface the remaining defect.

Fig. 3D.—Three months postoperative. Dots indicate position of flaps.

Fig. 3E.—Three months postoperative. Some additional work will be necessary for the little finger.

Fig. 4A.—Burn contracture of long, ring, and little fingers.

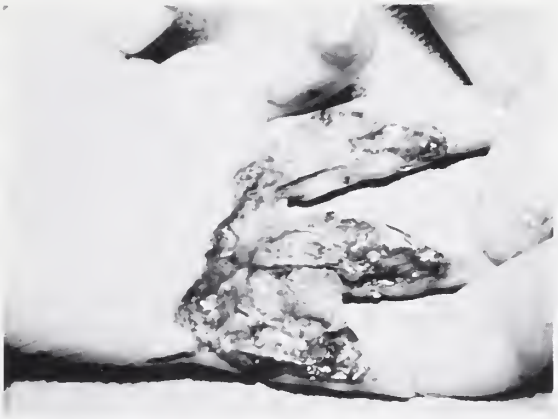

Fig. 4B.—Release.

Fig. 4C.—Three months post-grafting.

the proximal interphalangeal joint has been flexed for several months, the central slip of the extensor mechanism may have become attenuated. This should be checked when the contracture is released by stimulating the ulnar nerve per cutaneously at the wrist. If full extension does not occur, the extensor mechanism needs to be checked for adhesions. If free, additional force can be applied to the central slip by transferring one lateral band into the distal third of the central slip.

Burns are frequently associated with flexion contractures both when allowed to heal by secondary intent (Figs. 3, 4) and when grafted followed by postoperative shrinkage. These contractures are best treated by incision transversely across them with excision of a triangle of skin on the radial and ulnar side of the digit (Fig. 5). This then allows the defect to open up as a rectangle,

Fig. 5A.—Burn contracture of skin over volar aspect of index finger limiting extension. Incision outlined with excision of triangle based on midaxial line to produce rectangular defect as contracture is released.

Fig. 5B.—Transverse incision with removal of membranous portion of flexor tendon sheath to allow distal interphalangeal joint straightening. Note rectangular shaped defect.

Fig. 5C.—Resurfacing with cross-finger flap from dorsal aspect of long finger.

Fig. 5D.—Postoperative.

Fig. 5E.—Postoperative.

Fig. 6A.—Burn of volar aspect of long and ring fingers previously treated with skin graft. Postoperative shrinkage produced a 90° flexion contracture at proximal interphalangeal joint.

Fig. 6B.—Transverse release of contracture and membranous portion of flexor tendon sheath. The ring finger defect resurfaced with cross-finger flap from dorsal aspect of long finger. The defect of long finger resurfaced with cross-finger from dorsal aspect of index finger.

Fig. 6C.—Three months postoperative, extension.

Fig. 6D.—Three months postoperative, flexion.

Fig. 7A.—Postoperative and post-traumatic contracture of the proximal interphalangeal joint of little finger.

Fig. 7B.—Transverse release of contracture, tenolysis, release of volar plate and excision of volar half of collateral ligaments. Z-plasty distal palm.

Fig. 7C.—Resurfacing with cross-finger flap from dorsal aspect of ring finger.

the ends of which lie on the midaxial line and are little affected by the inevitable shortening of the graft-skin juncture. (In preference to the diamond-shape inset.)

Burns are usually not linear and therefore cannot be treated successfully with a Z-plasty (Fig. 6). If secondary contractures of the tendon sheath have occurred, then a window will need to be removed to allow digital straightening (Fig. 6c). A cross-finger flap is used to replace the skin defect and also provides a layer of fatty tissue for covering the exposed tendons (Fig. 6c). Even though a skin graft might occasionally "take" on the exposed tendons, excursion would be restricted. If the burn had been deep, the flexor and extensor tendons may need to be freed from any local scarring which might limit their excursion (Fig. 7).

Neurovascular bundles are said to occasionally shorten and prevent extension, but this can be overcome by proximal and distal "freeing up."

Avulsions.—These can usually be treated acutely with a full or split thickness graft. Sometimes additional skin at one side or the other should be removed depending on the configuration of the defect so that the graft-skin juncture is on the midaxial line or extends transversely across the finger. Proper self-imposed physiotherapy and night splinting will help prevent subsequent development of graft contracture.

Fig. 8A.—Severe Dupuytren's contracture of little finger.

Fig. 8B.—A transverse bucket-handle incision has been made over the proximal phalanx and a segment of infiltrated skin and palmar fascia removed from proximal phalanx and palm. A full thickness graft has been inserted.

Palmar Fascia.—Proliferation and shortening of the palmar fascia, as seen in Dupuytren's contracture, often limits extension of the metacarpophalangeal joint and the proximal interphalangeal joint. As previously stated, other structures shorten when contracture has been long-standing and the skin of the palm and volar surface of the fingers is usually so affected. This can be corrected by a longitudinal incision over the most prominent band with Z-plasties in the distal palm and proximal phalangeal area. Previously mentioned concommitant ligamentous shortening does not occur at the metacarpophalangeal joint with flexion contractures because these ligaments are held stretched during flexion due to their oblique position and the eccentric shape of the metacarpal head.[5] The volar plate may become adherent in the volar plate recess, however, and need freeing.

Occasionally, in prolonged and severe contractures of the little finger, the skin will be so infiltrated with thickened fascia that a Z-plasty will be impossible because of poor vasculature. In these cases the skin of the distal palm and proximal phalanx of the little finger can be excised and grafted with a full thickness graft (Fig. 8). A bucket-handle incision across the volar aspect of the proximal phalanx will open up into a rectangular defect and facilitate release of the flexor sheath and work upon the joint proper while still maintaining skin and subcutaneous coverage.

Flexor Tendon Sheath.—As previously mentioned, the membranous portion can shorten and need resection for complete extension. Artificial sheaths formed by the Hunter rod technique occasionally also shorten longitudinally and require surgical release.

Flexor Tendon Shortening.—Severed digital flexor tendons in which the distal end of the deep flexor has been shortened to advance the juncture

may produce a permanent flexion contracture. Tendon length is critical as demonstrated by Williams that a 1 cm increase in the deep flexor tendon length in the palm will with maximum flexion leave the fingertip 2.5 cm away from the distal palmar crease.[11] Sectioning the deep flexor and transferring it into an adjacent deep flexor tendon by interweaving is sometimes suitable for moderate contractures. To correct the more extensive shortening a tendon graft will often be necessary from the lumbrical level to the distal phalanx. This places junctures in favorable locations. Another approach to this problem is to incise the distal insertion of the deep flexor tendon and re-insert it into the middle phalanx under proper tension to produce balanced flexion of the proximal interphalangeal joint. The distal interphalangeal joint would then need to be fused in slight flexion for stability. This is often the best procedure with shortened tendons in the multi-operated little finger.

Shortening of the Entire Musculotendinous Unit.—Injuries of the forearm, and particularly those of a crushing nature, invariably result in a "dropped wrist" posture (volar flexion) which if allowed to persist will quickly result in shortening of all flexor musculotendinous units. This can be prevented by proper splinting of the wrist in extension (dorsiflexion) and thereby avoid subsequent extensive surgical procedures.

When a fixed flexion contracture has developed so that the patient cannot extend the fingers with

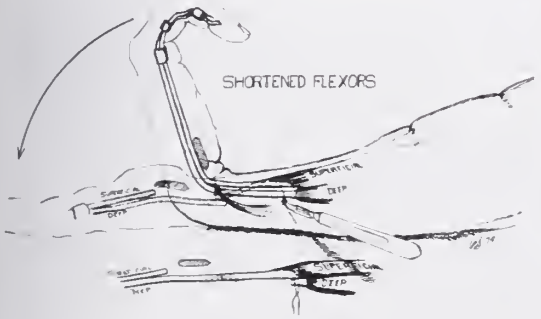

Fig. 9.—Shortened musculotendinous units with severe wrist contracture. Increased length of flexors is obtained by sectioning the superficial flexors distally at wrist and deep flexors proximally. The proximal end of superficial flexor is then joined to distal end of deep flexor. Proximal approximation of deep and superficial flexors then is done to assure adequate excursion.

Fig. 10A.—Flexion contracture limited to index finger with inability to extend index finger with wrist in neutral position.

Fig. 10B.—Superficial to deep tendon transfer as in 10A. Four months postoperative with complete extension of index finger even with wrist extended.

Fig. 10C.—Full flexion.

the wrist in neutral position or cannot extend the flexed wrist, surgical intervention is necessary. In the "muscle slide" operation the origins of the flexors are freed and allowed to advance distalward and reattach. This requires extensive dissection and the distal immigration of the muscles is limited by the neurovascular components which must be preserved.

Shortened flexors can also be lengthened by sectioning the superficial flexor* at the distalmost portion of the wrist, then sectioning the deep flexor at the musculotendinous junction (Fig. 9). The proximal superficial flexor is then sutured to the distal end of the severed deep flexor.[2] In order to maintain adequate excursion, the proximal end of the deep flexor is sutured side-to-side to the proximal portion of the superficial flexor. This operation works well for either a solitary digit (index) (Fig. 10) or when all fingers are involved. The wrist flexors have large tendons and a step sectioning will allow them to be adequately lengthened. The deep flexor of the thumb may be similarly lengthened.

The antebrachial fascia should be removed whenever tendon surgery is done in the forearm to eliminate this fixed structure to which tendons might become adherent and therefore lose their excursion. This also decompresses the area of postoperative swelling. Similarly the palmar fascia should be widely removed in the area of tendon junctures in the palm.

Secondary Flexion Contractures.—Secondary flexion contractures occur when the normally present antagonistic extensor forces are interrupted. They are seen in central nervous system abnormalities such as cerebral palsy and strokes, in peripheral nerve severance or compression, and in primary injuries to the extensor mechanism in the forearm, hand, and fingers. If not counteracted by proper splinting and self-imposed physical therapy, the part may maintain a prolonged flexed position with subsequent shortening of all structures previously mentioned.

Appropriate treatment is centered around correction, if possible, of the initiating cause as well as the secondary effects.

*Sublimus

Fractures of the metacarpals or phalanges, particularly interarticular fractures, dictate immobilization after reduction for satisfactory healing. Great care must be taken to immobilize the involved ray in the position of function.* Immobilization should, in most cases, be limited to three weeks after which guarded motion is started.[7] This can be gradually increased to full range of motion and strength by five weeks. In old healed interarticular fractures occasionally a bony exostosis may block extension and need to be surgically corrected at the same time so that complete digital straightening can be accomplished.

Rheumatoid Arthritis.—In rheumatoid arthritis one sees both primary and secondary flexion contractures. Intrensic shortening with subluxation of the metacarpophalangeal joints is often adequately corrected by shortening the bony architecture as the metacarpal head is removed at the neck as an implant arthroplasty is being done.[10] The surgical treatment of rheumatoid arthritis is not within the scope of this paper, but the treatment of contractures found in this disease generally follows the principles previously discussed.

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* Wrist extension, metacarpophalangeal joint at 45° flexion; interphalangeal joints at 10-15° flexion.

Lymphocytes and Human Disease
Cell-Mediated Immunity

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Abstract: An appreciation of normal and abnormal functions of cellular immunity is critical to understanding an increasing variety of clinical problems. When encountering an antigenic stimulus, the normal immune system responds through humoral and cellular systems. The humoral response is by B lymphocytes, which make antibodies, whereas the cellular response is by T lymphocytes, which participate in a delayed type of hypersensitivity. Activated T- or thymus-derived cells elaborate a number of biologically active substances. These are termed "lymphokines," or mediators of cell-mediated immunity. These substances include chemotactic factors, growth or proliferation inhibitory factors, blastogenic factor, macrophage migration inhibitory factor, macrophage activating factor, transfer factor, interferon, and others. Cell-mediated immunity participates in normal cutaneous reactivity, immune surveillance, homograft rejection, and host defenses against intracellular infection. Cell-mediated immunity is abnormal in an increasingly recognized number of clinical states. These include cancer, congenital immunodeficiencies, certain infections, advanced age, chronic renal or hepatic disease, and autoimmune diseases. As understanding of cell-mediated immunity increases, it should be possible therapeutically to modulate abnormal delayed type of hypersensitivity in disease.

On observing activated lymphocytes 35 years ago, Arnold Rich and co-workers wondered, "What is the nature of these cells which proliferate to such a marked degree . . . and what function does this intense activity serve?"[1] For many years thereafter the role of the lymphocyte in health and disease remained poorly understood. Only in recent years has interest in lymphocyte function been intense, and the answers to Rich's questions are at hand. This review will summarize our current understanding of lymphocytes and immunity and will focus principally upon cell-mediated immunity (CMI).

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Development of Immunity

To place the biological importance of CMI in proper perspective, it is necessary to review briefly the development of the entire immune system. Pluripotential stem cells are thought to originate in the bone marrow. Lymphoid cells are derived from these stem cells and can then be programmed into further stages of development. Those cells destined to participate in humoral immunity are subjected to certain inductive influences and then become "B" cells, analogous to similar cells derived from the bursa of Fabricius in birds. Other lymphocytes come under the influence of the thymus gland and are called thymus-derived or "T" cells. These lymphocytes take part in the processes of cellular immunity, which is synonymous with delayed type of hypersensitivity (DTH).[2,3]

The immune response reflects a cooperative interaction between these T and B lymphocytes and other cells. After antigens are encountered by the host, they are processed by phagocytic macrophages. Antigens are presented to B lymphocytes and interact with immunoglobulin receptors on their cell-surface membranes. Following antigen stimulation B cells proliferate and differentiate into plasma cells. Plasma cells synthesize and secrete immunoglobulins. T cells are thought to exert "helper" and "suppressor" influences on B cells and can thus modulate normal humoral immune responses. T cells lack surface immunoglobulins but are still able to interact with antigen through mechanisms that are still poorly understood. Upon antigenic stimulation T cells proliferate and produce a number of biologically active substances called "lymphokines," or mediators of cellular immunity.[2,4]

Mediators of Cellular Immunity

The events we recognize and describe as DTH are thought to be mediated by the release of biologically active substances from activated T lymphocytes.[5,6]

The list of lymphokines that have been identified is lengthy and continues to grow (Table 1). These include factors that inhibit the random migration of normal macrophages and can activate macrophages, factors that are chemotactic to other cell types, substances (blastogenic factor) that recruit unsensitized lymphocytes and induce them to proliferate, cytotoxic materials (lymphotoxins), growth or clonal and proliferation inhibitory factors, and interferon. Additional factors, only recently described, may inhibit complement activation (complement inhibiting factor) or enhance bone resorption (osteoclast activating factor). Although lymphokines exert a number of biologically important effects, they are not well characterized. It is not certain, for example, whether these are all different substances or only a few substances with several activities.[5,6] It should be apparent that these factors theoretically can be combined to mediate an inflammatory reaction with many of the features of DTH. A small number of immunologically stimulated lymphocytes, by elaboration of lymphokines, can lead to the DTH reaction.

Functions of Cell-Mediated Immunity

The biological implications of this series of events are profound. As noted earlier, prior exposure or sensitization to antigen is recalled by rechallenge with antigen and can result in DTH.

TABLE 1.—LYMPHOKINES.

1. Factors Affecting Macrophages
   (a) Migration Inhibitory Factor (MIF)
   (b) Macrophage Activating Factor (MAF)
   (c) Macrophage Aggregating Factor (MAF)
   (d) Migration Enhancement Factor
   (e) Macrophage Spreading Factor
2. Chemotactic Factors (CF)
   (a) CF for Mononuclear Cells
   (b) CF for Eosinophils
   (c) CF for Polys
3. Blastogenic (mitogenic) Factor (For lymphocytes)
4. Cytotoxic Factors (Lymphotoxins)
5. Growth Inhibiting Factors
   (a) Clonal Inhibitory Factor
   (b) Proliferation Inhibitory Factor
6. Skin Reddening (reactive) Factor
7. Interferon
8. Transfer Factor
9. Complement Inhibitory Factor
10. Osteoclast Activating Factor
11. Leukocyte Inhibitory Factor
12. Colony Stimulating Factor

This observation is used in commonly performed skin tests. Contact allergies, such as poison ivy and nickel sensitization, are predominantly mediated by DTH. Homograft rejection, also, principally occurs by mechanisms of cellular immunity. The cellular immune system is thought to perform the function of "immune surveillance" by which malignant clones of cells are eliminated. This same immune mechanism is largely responsible for host responses to intracellular infections such as viruses, certain protozoa, fungi, or bacteria. As will be discussed shortly, abnormal CMI mechanisms may be important in the pathogenesis of autoimmune diseases.[2,3]

Evaluation of Cell-Mediated Immunity

Since the normal cellular immune response can be seen to play an important role in maintaining health and abnormal CMI may be important in producing disease, it is important to be able to evaluate the integrity of this system in many clinical situations. Evaluation can readily and simply be done in office practice, supplemented by the more sophisticated techniques of the investigative laboratory. Absolute small lymphocyte count and the development of cutaneous reactivity to common antigens (such as Candida albicans, streptokinase-streptodornase, trichophyton, mumps or purified-protein derivative) are easily performed. Techniques exist to enumerate those circulating lymphocytes that are T cells (approximately 70%). In vitro techniques characterize lymphocyte proliferation in short-term tissue cultures (blast transformation or uptake of tritiated-thymidine into newly synthesized nuclear material) in response to stimulation by antigens or nonspecific mitogens (phytohemagglutinin, concanavalin A, pokeweed, or allogeneic cells). Similarly the production of lymphokines in vitro can be assayed. Other methods for assaying T-cell function include the ability to mount a homograft rejection reaction, to induce contact sensitization to dinitrochlorobenzene, or to demonstrate radiological presence or absence of the thymus gland.

Role of Cell-Mediated Immunity in Disease

Cell-mediated immunity does not function normally in a number of recognized clinical situations (Table 2). As interest in CMI expands, more examples of disease states where DTH function is impaired continue to be recorded. Those diseases with the most striking abnormalities of CMI are immunodeficiency diseases where CMI

Table 2.—Diseases with Abnormalities of Cell-Mediated Immunity.

1. Congenital
   (a) Severe combined immunodeficiency
   (b) Di George syndrome
   (c) Nezelof syndrome
   (d) Ataxia telangiectasia
   (e) Wiskott-Aldrich syndrome
2. "Acquired"
   (a) Infectious diseases
      (1) Lepromatous leprosy
      (2) Chronic mucocutaneous candidiasis
      (3) Viral infections
      (4) Other
   (b) Malignancies
      (1) Hodgkin's disease, lymphoma, leukemia
      (2) Other
   (c) "Metabolic"
      (1) Renal disease
      (2) Hepatic disease
   (d) Rheumatic disease
      (1) Rheumatic arthritis, juvenile rheumatoid arthritis
      (2) Systemic lupus erythematosis
      (3) Poly-dermatomyositis
   (e) Other
      (1) Sarcoid
      (2) Burns
      (3) Age
      (4) Pregnancy
      (5) Immunosuppression

is congenitally absent or impaired, as listed in the table. Patients with these diseases lack normal defenses against intracellular infections and malignant transformation. As a result, these patients die prematurely. Suppression of CMI also appears in a number of clinical states. These include malignancies, certain chronic infectious diseases, chronic renal disease, cirrhosis, sarcoidosis, rheumatic disease, burns, advanced age, and pregnancy. These "abnormalities" are usually characterized by inappropriate blunting of skin tests or in vitro reactivity to common antigens or mitogens.[2-7]

Conclusion

An appreciation of the normal and abnormal function of the immune system, and cellular immunity in particular, is critical to understanding an increasing variety of clinical problems today. As our understanding of CMI increases so will our recognition of its role in health and disease. It is already possible to augment CMI function by thymus or bone-marrow transplantation, use of transfer factor, immunization (BCG), or pharmacologic means. Likewise, it is possible to suppress CMI by use of anti-inflammatory or immunosuppressive agents. Thus, in the future it may be possible therapeutically to manipulate abnormal cellular immune function in disease so as to restore health.

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Paraesophageal Hernia and Gastric Volvulus

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Abstract: Gastric outlet obstruction associated with paraesophageal hernia is more common than usually appreciated. In the elderly patient the mortality rate is high. The diagnosis is largely radiographic and depends upon chest and barium swallow radiographs. Surgery should be delayed until there is adequate fluid and electrolyte replacement. Reduction of gastric herniation with anterior gastropexy through an abdominal incision is the procedure of choice in the poor risk patient. The procedure should be done electively before obstruction occurs. Five case histories are presented to stress these points.

Volvulus of the stomach is recognized with increasing frequency as a cause of profuse and protracted vomiting. Obstruction which occurs with both acute and chronic volvulus usually is associated with diaphragmatic hernia either congenital or acquired. In paraesophageal hernia gastric volvulus most often causes obstruction but in rare instances there may be other causes.[1] Obstruction must be recognized early and treated aggressively. Complications of strangulation and fluid and electrolyte loss lead to 90% to 100% mortality.[2,3]

Review of a community hospital's records for a four year period revealed three cases of gastric volvulus associated with diaphragmatic hernia.

Report of Cases

Case 1.—An 88-year-old woman was admitted with chief complaint of nausea and vomiting of eight days duration. Episodes of vomiting had occurred for the past year. There was no history of pain, melena or hematemesis. Physical examination showed her to be in acute distress. Blood pressure was 170/80; pulse 130/min., and respirations 24/min. The skin and mucous membranes showed mild to moderate dehydration and atrial fibrillation was present with rapid ventricular response. The abdomen was moderately distended and diffusely tender without rigidity or rebound tenderness.

The laboratory reported hematocrit 44, BUN 56, Na 133, K 3.2, Cl 88, and CO_2 30. Chest x-ray showed eventration of the dome of the left diaphragm (Figs. 1, 2). An upper GI barium examination revealed a dilated stomach 70% above the diaphragm and the gastroesophageal junction normally located. Present were a large paraesophageal hiatus hernia with partial gastric outlet obstruction and an organoaxal volvulus (Fig. 3).

Following fluid and electrolyte replacement and digitalization, the patient was taken to surgery on the seventh hospital day where reduction of the herniated stomach, correction of the volvulus and anterior gastropexy with gastrostomy were carried out. There was no evidence of gangrene.

The postoperative course was complicated by pneumonia, parotitis, congestive heart failure and pulmonary edema. She expired on the eighth postoperative day.

Case 2.—A 76-year-old man was admitted in acute distress with chief complaint of nausea and vomiting of three hours duration. He related a history of dull, aching epigastric pain. Physical examination revealed

Fig. 1 (Case 1).—Chest x-ray demonstrates apparently elevated left hemidiaphragm.

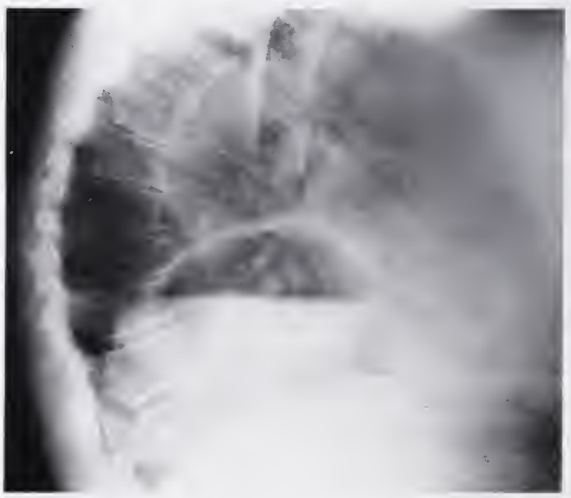

Fig. 2 (Case 1).—Lateral view of chest x-ray demonstrates elevated left hemidiaphragm with air fluid level in stomach.

Fig. 3 (Case 1).—Large paraesophageal hiatal hernia with gastric volvulus and partial obstruction.

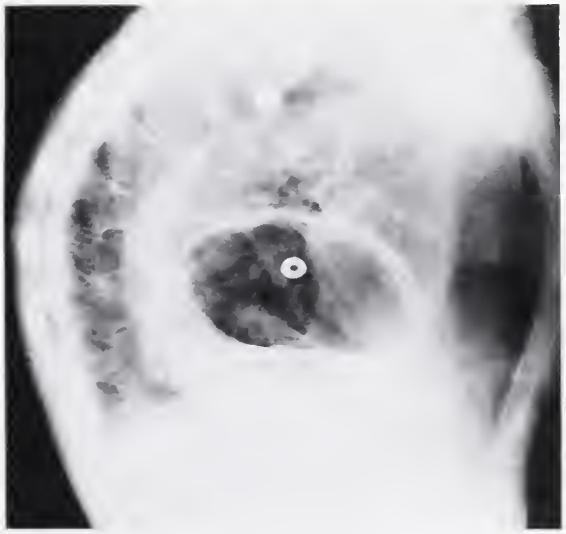

Fig. 5 (Case 2).—Lateral view of chest x-rays reveals double air fluid levels within thoracic cavity.

Fig. 4 (Case 2).—Marked elevation of left hemidiaphragm, easily confused with pulmonary atelectasis.

dehydration, tenderness in the epigastrium and left hypogastric regions with guarding and moderate distention.

On admission the laboratory recorded hematocrit 54, BUN 22, Na 142, K 3.9, C1 98, and CO_2 36. Chest x-ray showed eventration of the left hemidiaphragm (Figs. 4,5). The upper GI examination revealed the gastric fundus to be elevated over the esophagogastric junction with two air-fluid levels above the diaphragm. Gastric outlet obstruction with volvulus was identified (Fig. 6).

The patient was taken to the operating room on the second hospital day where reduction of the herniated stomach, correction of the volvulus, gastrostomy and anterior gastropexy were performed through a midline abdominal incision.

Fig. 6 (Case 2).—Barium swallow confirms gastric volvulus and obstruction.

Fig. 7 (Case 3).—Chest x-ray demonstrates nasogastric tube coiled above the diaphragm within the chest cavity.

Fig. 8 (Case 3).—Barium examination reveals paraesophageal hernia, gastric volvulus, and obstruction.

Fig. 9 (Case 3).—Postoperative barium x-ray confirms reduced hernia and resolved gastric volvulus.

Fig. 10 (Case 3).—Barium x-ray demonstrates gastroesophageal junction in position below diaphragm while gastric air fluid level is above diaphragm.

The postoperative course was complicated by pulmonary insufficiency related to chronic obstructive pulmonary disease. He was discharged 18 days following surgery. Three years later he had no gastrointestinal symptoms and the stomach was confined to the abdomen.

Case 3.—A 66-year-old man was admitted with chief complaint of nausea and vomiting of two weeks duration which had become progressively more severe in the two previous days. He denied pain, hematemesis, melena and other symptoms. Physical examination revealed a dehydrated patient, disoriented, in acute distress, with blood pressure 120/60, pulse 84/min., and respirations 28/min. The abdomen was distended, tympanitic, and there was epigastric tenderness. Admission laboratory data showed hematocrit 50, BUN 41, Na 152, Cl 94, K 4.1, and CO_2 40. Stool guaiac was strongly positive.

Fig. 11 (Case 3).—Gastric volvulus and paraesophageal hernia with portion of stomach lying on top of diaphragm.

Chest x-ray showed an elevated left hemidiaphragm with retrocardiac density and a nasogastric tube projecting above the diaphragm within the chest (Fig. 7). Upper GI examination revealed a paraesophageal hernia, volvulus of the stomach, and gastric outlet obstruction (Fig. 8). Nasogastric intubation released 1,500 cc. of gastric content but the obstruction persisted.

After intensive fluid and electrolyte replacement, the patient was taken to the operating room on the fifth hospital day. Through an abdominal incision, the gastric herniation was reduced, volvulus corrected and anterior gastropexy performed. His postoperative course was uncomplicated save for prolapsed hemorrhoids, and he was discharged on the 13th postoperative day.

After discharge upper GI examination demonstrated complete reduction of the stomach (Figs. 9, 10, 11). The patient is asymptomatic eight months postoperatively.

Discussion

In an elderly patient profuse vomiting is ubiquitous for many surgical conditions and some medical ones. That it occurs with paraesophageal hiatus hernia, gastric volvulus and outlet obstruction must be considered.

If the chest x-ray demonstrates apparent elevation of the left hemidiaphragm, this suggests diaphragmatic herniation of the stomach into the left chest with volvulus. The shadow represents the stomach lying on top of the diaphragm. Barium swallow studies are diagnostic. [1,4-7]

Ten to 20% of diaphragmatic hernias are congenital and 80% to 90% acquired. [2,8] Penetrating wounds of the abdomen or chest can produce a defect through which the bowel may herniate.[6,9] Rapid, blunt injury to the abdomen may result in rupture of the left diaphragm.[6] The diaphragm may rupture following surgical incision and closure.[10,11] Johnson and Twente emphasize the danger of diaphragmatic incision dehiscence with herniation of the stomach into the left chest and advocate meticulous closure either by overlap or imbrication with prolonged nasogastric decompression.[11]

Congenital hernia is paraesophageal and commonly present for many years.[4,7,12] It bears a peritoneal covering which is lacking in the acquired type.

Obstruction is likely to be produced by two mechanisms.

1. The fundus of the stomach, often with the spleen, rises through the diaphragmatic defect, rotating superiorly, with the point of rotation being the fixation of the lesser curvature of the stomach at the gastroesophageal junction. Fixation is caused by attachments of the left gastric artery and its ligaments. In the coronal plane anterior protrusion of the greater curvature and spleen occur so that 180 degree rotation takes place with the posterior surface of the stomach appearing anteriorly. With progression of the process the antrum and pylorus enter the chest, lying anterior to the gastroesophageal junction which normally is situated below the esophageal hiatus. Volvulus at the gastric outlet may occur.[7,12]

2. When the antrum or cardia partially descends back into the abdomen, distention from swallowed food and air increases the size of the body and fundus, compressing the gastric outlet.[1,7] Gastric secretions collect exacerbating the obstruction. Vomiting incompletely empties the stomach because of the site of obstruction and extraabdominal location of the displaced stomach.

In our patients surgery was delayed when possible for fluid and electrolyte replacement and management of associated cardio-respiratory disorders. Necrotic bowel requiring resection was not encountered. Surgery was limited to reduction of the hernia and anterior gastropexy, often with gastrostomy. The patients' clinical condition precluded repair of diaphragmatic defects.

The choice of operative procedures depends upon the patient's clinical status, the minimum procedure being reduction of the herniated stomach and anterior gastropexy. Gastrostomy was reserved for the patient in whom removal of

the nasogastric tube would improve the respiratory toilet. Reduction of the hernia and closure of the diaphragmatic defect, particularly through a transthoracic approach, should be reserved for patients in better condition. The 14 patients in Beardsley and Thompson's series were operated upon via the abdomen.[2] We used the same approach.

Both our surviving patients with anterior gastropexy have been asymptomatic on follow-up and definitive repair of the diaphragmatic defect may not be necessary. Anterior fixation of the stomach probably prevents the transverse colon from herniating into the diaphragmatic defect.

Surgical correction in the elderly patient is hazardous, chiefly because of associated metabolic and cardiorespiratory diseases. It should be performed electively, when possible, before obstruction occurs. Simple reduction of the gastric herniation and anterior gastropexy is the operation of choice in the high risk patient. The incidence of complications is high and includes bleeding, ulceration, respiratory insufficiency, incarceration and strangulation of the omentum and bowel.

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One-Half Century of Tularemia in Florida

Gerald L. Hoff, Ph.D., William J. Bigler, Ph.D.
and E. Charlton Prather, M.D.

Abstract: Two cases of tularemia were reported to the Florida Division of Health in November 1974. Both patients were white men in their mid-20s and had contracted the infection from a wild rabbit. For the half century, 1924-1973, there were 247 cases, the lowest incidence in the southeastern United States. All areas of the state had cases, reporting occurrences every month as a result of year round hunting of wild rabbits. November demonstrated peak incidence. According to case records, the Division's annual reports and morbidity statistics, white men were most commonly infected.

Two cases of tularemia were reported to the Florida Division of Health in November 1974. Both patients were white men in their mid-20s. Clinical diagnosis was confirmed by isolation of *Francisella tularensis* from scrapings from a lesion on the thumb of one patient and by four-fold rises in agglutinin titers in sera from both of them. The infection had come from a wild rabbit, *Sylvilagus palustris,* killed in Palm Beach County. This is the first time in the United States that this particular species has been documented as the source of the disease. In December investigation among animals in the area where the rabbit had been killed failed to show the bacterium in liver and spleen specimens. Serologic examination revealed one reactor — an opossum.

Reports for Half Century

According to case reports, Division of Health annual reports and morbidity statistics, tularemia among humans is infrequently reported in Florida.

For the 50 years, 1924-1973, there were 247 cases, the lowest number for any southeastern state (Table 1) and .7% of the United States total of almost 33,700 cases. Of the total cases, 190 occurred in the 20 year period 1934-1953. In the preceding decade there were 20 cases and in the 20 years following, 1954-1973, only 37.

The disease has been reported from all over the state. For the 200 cases in which a county is recorded, Dade and Duval accounted for 39% (Fig. 1). Of the 205 cases for which the month of infection is recorded, 111 or 56% occurred between November and March. November with 35 cases had the highest number for any month.

Race is given for 172 cases and 127 or 74% were white and 45 or 26% colored. Sex and age are provided for 50 cases, 30 men, 17 women, and three boys, and 34 of them were between 30 and 49 years of age.

Records concerning fatal cases are available after 1945. Of 158 cases reported since that time there have been five deaths, all white men in their mid-20s from Duval, Hendry, Jefferson and Osceola Counties. Only one death was attributed to a rabbit contact, but in 25 nonfatal cases where source of infection is recorded, 21 implicated wild

Table 1. — Comparison of Reported Cases of Human Tularemia in Southeastern States, 1924-1973.*

	Florida	Georgia	Alabama	Mississippi	South Carolina	North Carolina
1924-1949	161	1310	302	607	391	496
1950-1955	57	288	64	163	53	103
1956-1961	11	125	42	83	15	63
1962-1967	7	84	13	18	9	25
1968-1973	11	19	5	8	3	20
Total	247	1826	426	879	471	707

*Data for 1924-1949 from all states except Florida from Yeatter, R. E., and Thompson, D. H.: Tularemia, Weather and Rabbit Populations, Bull. Ill. Nat. Hist. Survey 25(6):351-382, 1952. Data for 1950-1973 from records of U.S. Public Health Service.

From the Bureau of Preventable Diseases, Division of Health, Department of Health and Rehabilitative Services, State of Florida, Jacksonville.

Fig. 1.—Distribution of 200 human cases of tularemia in Florida for the half century 1924-1973.

rabbits. A domestic rabbit, squirrel, opossum and unspecified rodent accounted for the remainder of nonfatal cases.

Between 1965 and 1973, 2,195 sera obtained from 23 species of wild animals trapped in 40 counties were tested for agglutinins to *F. tularensis*. Forty animals from seven species had positive titers for tularemia, 26 of them were raccoons (Table 2). Animals whose serum gave a positive reaction were from 16 counties; eight of these had reported human cases, Alachua, Dade, Duval, Jackson, Manatee, Orange, Sarasota, and St. Johns. They tended to be found in clusters with most being associated with hardwood swamps in north and central Florida. In south Florida they were found primarily in estuarine mangrove and cypress-everglades habitats.

The low incidence of confirmed human cases of tularemia, low prevalence of antibodies in wild animals, and absence of any recorded zoonotic outbreak of the disease are strikingly different from neighboring states.[1,2] The case fatality ratio between 1945 and 1973 of 3.2%, however, is triple that reported nationally from 1950 to 1968.[3]

The data suggest that the principal mammalian vector of human tularemia is wild rabbits. The domestic rabbit has been incriminated only once. Wild rabbits are hunted year round with about 375,000 being killed each year.[4] This may account for the rather constant incidence of cases reported between April and October. The increase in monthly incidence of cases in November and subsequent trailing off through March may be attributed to the fact that in November most regulated hunting begins, thereby resulting in more hunting pressure on rabbits. As various

Table 2.—Serologic Results on 2,195 Wild Animals for Agglutinins to *Francisella tularensis*

	Number Tested	Number Positive	Percent Positive
Raccoon	801	26	3.2
Opossum	451	5	1.1
Armadillo	68	1	1.5
White-tailed deer	56	2	3.6
Cotton rat	359	3	0.8
Cotton mouse	153	2	1.3
Oldfield mouse	3	1	33.3

Tested but found negative for infection were 1 striped skunk, 47 marsh rabbits, 4 cottontail rabbits, 10 gray fox, 1 bobcat, 3 gray squirrels, 85 rice rats, 9 Norway rats, 54 black rats, 2 wood rats, 47 house mice, 9 feral hogs, 16 feral cats, 1 feral dog, 3 snakes, and 12 turtles.

regulated seasons close, the number of hunters decrease and the pressure lessens.

The prevalence of agglutinins in the species of wild animals tested is approximately one tenth that observed in comparable animal surveys from states reporting more human cases than Florida.[1,2,5] Clusters of seropositive animals tended to be associated with swampy or estuarine environments. This association also has been reported from Georgia.[4] Suitable vegetative cover and land use in the surrounding areas tend to attract and concentrate many wildlife species and their parasites. Consequently conditions are created for potentially establishing a focus of tularemia endemicity.

Tick vectors for tularemia are found in Florida, *Dermacentor variabilis* statewide and *Amblyomma americanum* in north Florida and along the gulf to Hillsborough County. Of 433 raccoons and 179 opossums captured between 1969 and 1971 in various habitats, 78 raccoons and 49 opossums had ticks on their head, chest or forelegs. A total of 86% of 264 ticks from raccoons and 89% of 224 from opossums were identified as *D. variabilis*.

Conclusion

The low number of tularemia cases in Florida cannot be attributed entirely to absence of the infection or of suitable arthropod vectors. Both have been found throughout the state. This phenomenon appears to result from the small number of rabbits killed by hunters, apparent low level of bacterial activity in associated wildlife species, probable focal distribution of the bacterium in wild animals, and man's nonintrusion into established areas of tularemia activity. The small number of human cases also may be attributed to decreased clinical suspicion, missed cases, and availability of streptomycin.

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Special Articles

The New Florida "Rape" Law

Arthur Frederick Schiff, M.D.

Traditionally rape has been defined as "the unlawful carnal knowledge of a woman by force and against her will"[1] or "the unlawful carnal knowledge of a woman by a man forcibly and against her will."[2] Florida statutes formerly defined the crime as "ravishing and carnally knowing a female of the age of ten years or more, by force and against her will. . . ."[3] Herzog takes exception to the phrase "against her will."[4] He offers the definition "sexual intercourse with a woman or girl forcibly and without her consent"[5] but is not satisfied with it because in law sexual intercourse is not necessary to constitute the crime. Sufficient lawfully is the slightest penetration of the female genitalia.

Components of Rape

Four components make up the crime. First, the victim must be female, child or adult, and not the wife of the assailant. The last was made clear centuries ago by Lord Hale who declared: "The husband cannot be guilty of a rape committed by himself upon his lawful wife for by their mutual matrimonial consent and contract the wife hath given up herself in this kind unto her husband which she cannot retract."[6]

The second component is nonconsent. The victim does not give her consent to coitus freely with no equivocation or mental reservation. An exception is a girl under the "age of consent," which varies from state to state but is usually between 16 and 17, who agrees to have sexual intercourse but her consent is null and void in the belief that she does not know her own will nor realize the full impact of the act. Not all states, however, protect her by law. Consent must be consciously given with the woman in full possession of her senses, not asleep, intoxicated, under the influence of drugs, insane, or feeble-minded. In some jurisdictions[7] the accused may use as a defense that he was not aware the woman was either insane or feeble-minded and that force was not used. Yet, another jurisdiction[8] holds that ignorance of a woman's lack of mental capacity to consent is a poor defense.

The third component is force necessary to overcome the victim's will to resist. Professor Glaister[9] makes the point that the victim must maintain her resistance to the last, surrendering only when overcome by "unconsciousness, complete exhaustion, brute force, or fear of death." He emphasizes that she must resist "to her utmost." Evidence of this resistance is expected and sought. Florida law is more lenient. The actual raw force can be transmitted to the mind. No hands may be laid upon the victim; yet she can be so intimidated by "an array of physical force"[10,11] that she dares not resist. A Georgia court put it succinctly: "though a man lay no hands on a woman, yet, if, by an array of physical force, he so overpowers her mind that she dare not resist, he is guilty of rape by having the unlawful intercourse."[12]

Very rarely have I seen severe injuries. In only two cases out of a thousand were there any fractures. In one, the victim, an elderly woman, was badly beaten and died. It was theorized that she sustained the injuries including a subdural hematoma less because she resisted and more bebecause the assailant or assailants were sadistic.

The last component is penetration. Legally, the degree is not of any great consequence but practically there is great difference. Penetration of a virgin may be so slight, say ¼ inch between the labia, as not to disrupt the hymen making medical corroboration almost impossible. On the other hand, discovery of a recently ruptured hymen together with motile spermatozoa in the upper third of the vaginal barrel leaves no doubt as to the nature of the penetration. In the absence of hard evidence, i.e. injury or presence of spermatozoa, the examiner supposes intercrural intercourse has taken place. Even this action leaves doubt as to legal penetration. If the labia minora parted and allowed slight entrance to the shaft of the penis, then penetration did occur. Many times this is a problem the judge, jury, attorneys, investigating officers, medical examiner, and even participants in the act cannot honestly solve.

Dr. Schiff is Deputy Medical Examiner for Dade County.

Definition Mutating

Today with liberal reforms and rapid changes in practically every field of human endeavor as well as in basic and advanced technology, it is not surprising that the definition of rape is mutating as thoroughly as those definitions appearing in ethics, morality, and social interrelationships.

Four of the 50 states in addition to Florida have recently modified rape laws in one way or another. The Connecticut, Iowa, and New York changes have long been overdue. In relation to the whole these are small steps, yet in the right direction. The nature of the crime is such, clandestine and cloaked, that many times it is impossible to secure independent evidence in the majority of cases. Because of the corroboration rule, many reliable and credible complainants, aggrieved and frustrated, saw the offenders go free. The situation has now been corrected.

Florida and Michigan have gone "all the way." The Florida bill was filed June 3, 1974 and became law Oct. 1, 1974. The Michigan bill became law on Nov. 1, 1974. They appear to have scrapped the old laws and started anew with concepts, objectives and principles more in keeping with the times. The laws of both states studiously avoid any reference to the word "rape." Instead, Florida employs the phrase "involuntary sexual battery" and Michigan "criminal sexual conduct."

In the context of the rape laws, there has been no question concerning the word "penetration," yet Michigan becomes more explicit by defining and employing the phrase "sexual penetration." Curiously enough, in three definitions ("mentally defective," "mentally incapacitated," and "physically helpless") the Michigan law is identical to the Florida one.

Focusing on the Florida "involuntary sexual battery," one sees an attempt to redefine sex crimes and to unify the sex crime laws. For example, the forcible sodomy law[13] ruled unconstitutional in 1971 by the Florida Supreme Court found a place in the new law's definition of "sexual battery." Also, by definition, the law does not apply to consenting adults, and fellatio and cunnilingus have been transmuted from "any unnatural and lascivious act with another person"[14] to "oral, anal, or vaginal penetration by or union with the sexual organs of another."[15]

A major departure from the old law and even from the traditional definition of rape is that involuntary sexual battery can be committed upon a person of either gender. This is emphasized in the definition of "victim" which means "the person alleging to have been the object of a sexual offense." There can be no misunderstanding the phrase: ". . . due to any other act committed upon that person without his or her consent." Thus, in no uncertain terms, protection is extended to the sexually assaulted male as well as the female and takes the place of the eliminated felony sodomy statutes.

Another important change from the ancient statutes is in the complete definition of "sexual battery," to wit, "oral, anal, or vaginal penetration by or union with the sexual organs of another; or the anal or vaginal penetration of another by any other object, provided, however, sexual battery shall not include acts done for bona fide medical purposes."

In addition to carnal knowledge or sexual intercourse, i.e., vaginal penetration by "the sexual organs of another," the lawmakers took into consideration digital manipulation and insertion of any object. The lawmakers carefully point out that the insertion of a speculum into the vagina, cystoscope into the urethra, sigmoidoscope into the anus for "bona fide medical purposes" is specifically exempt from this law.

As with rape, emission of semen is not an element of sexual battery. Ths detail is made quite clear in the Michigan law,[16] and is understood in the Florida law by its omission.

Portions of the old law have been picked up verbatim and placed in the new law. One example is the "common law rule 'that a boy under fourteen (14) years of age is conclusively presumed to be incapable of committing the crime of rape' shall not be in force in this state."[17] The capability of a person to achieve an erection and to penetrate is a question for the jury. In the new law, however, neither an erection nor penetration is necessary. If a 14-year-old boy or even a 12-year-old boy forcefully puts his finger into the vagina or even anus without the victim's consent, he can be charged with "involuntary sexual battery."

Another example is retaining the section concerning the unlawfulness of allowing the victim's name, address or "other identifying fact or information" to be publicly exposed.[18] This provision, of course, is to spare the victim any needless embarrassment and is an inducement to have her come forward to report the crime.

Penalties

Depending upon whom the crime is committed and the differing degrees of force employed, the law sets forth different penalties. For example, if the offender is 18 years or older and the victim 11 years or younger, a capital felony punishable by life imprisonment is involved. If the victim is over 11 years, does not give consent and the offender "threatens to use a deadly weapon or uses actual physical force likely to cause serious personal injury," he can be found guilty of a life felony.

There are two other degrees (first and second) dependent upon a fixed set of circumstances in which the accused can be sentenced to "a term not exceeding thirty (30) years" and "a term of imprisonment in the state prison not exceeding fifteen (15) years" respectively.

A key provision allows the victim to be questioned outside the presence of the jury concerning prior consensual sexual activity in order "to establish a pattern of conduct or behavior on the part of the victim which is relevant to the issue of consent." The testimony would then be admitted as evidence or denied at the discretion of the court.

Although the noncorroboration rule has been in effect in Florida for years, it is specifically mentioned in the new law. However, the judge may instruct the jury as to the quality and the weight of the evidence.

Comment

Among attorneys and the judiciary the new law is generally conceded to be an improvement. Some criticism, however, has been leveled at it. An attorney stated that "some portions make real good sense to me and some parts we'll have problems with." One point he finds difficult to understand is that portion of the definition of sexual battery which states it "means oral, anal, or vaginal penetration by or union with the sexual organs of another." "Union with" is his hang-up. Could this be construed as rape of a male by a female? In other words if the female manages to get the penis into her vagina then "union with" has been achieved. Another puzzling phrase is "violence not likely to cause serious injury." It is ambiguous, vague, and almost evasive.

In the section spelling out the six conditions under which an offender "shall be guilty of a felony of the first degree," I believe the lawmakers should have studied a portion of the New York Code[19] which states ". . . or when she is in the custody of the law, or of any officer thereof, or in any place of lawful detention, temporary or permanent." It is true that the new law gives one of the circumstances as "when the victim is older than eleven (11) but less than eighteen (18) and the offender is in a position of familial, custodial, or official authority over the victim and uses this authority to coerce the victim to submit." I believe the point should have been more specific.

Some attorneys believe the word "assault" should have been included in the title as in "Involuntary Sexual Assault and Battery." Assault can be committed with no contact between offender and victim. The victim only needs to have a reasonable apprehension that an aggressor intends to inflict some kind of bodily injury.

A female attorney stated that the new law should have had some provision whereby a husband can be prosecuted for raping his wife. She gave a typical illustration. A husband and wife separate but not legally. She moves out and as her life begins to take on more meaning she thinks in terms of divorce. After a period of ten months the husband shows up and wants to have intercourse. He is denied, but has intercourse with her forcibly, against her will, and without her consent. Normally this would constitute the crime of rape, but no legal separation order was in effect. They were man and wife.

Basically, the majority of attorneys consider the law to be a more realistic attitude toward sex crimes. The legislature has made a good effort at improving statutes believed to be deficient. "Now," commented one attorney, "all we need are judges to enforce it."

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16. M.C.L.A. Para. 750.520 a (h).
17. Florida Statutes 794.02.
18. Florida Statutes 794.03.

▶ Dr. Schiff, 3200 Kirk Street, Miami 33133.

Maimonides
Physician, Philosopher, Jurist

Richard S. Hodes, M.D.

Editor's Note: September is the month of Rosh Hoshana, the Jewish New Year, and Yom Kippur, the Day of Atonement.

In commemoration of these important events, Dr. Richard S. Hodes, Treasurer of the Florida Medical Association, has written this special article. It reiterates the many and remarkable contributions of the Jewish physician—philosopher—jurist, Maimonides, who did much of his writing while a member of the court of the Muslim King, Saladin.

"From Moses to Moses there was none like Moses." The second Moses was the consummate physician, philosopher and jurist, Rabbi Moses ben Maimon, the immortal Maimonides. As modern Jews look forward in September 1975 to Rosh Hoshana, celebrating the New Year 5736, followed in a week by Yom Kippur, the Day of Atonement, it is fitting to reflect upon the work, the vision and the persistent influence of the 12th Century prophet.

Born the son of a scholar at the Western end of Moslem civilization, in the cultured city of Cordova, Spain, Maimonides had barely begun his studies when he and his family became refugees. Here on the Iberian peninsula, where Moslem and Christian faced each other in hate and fear and where there was constant political turmoil, the Maimon family wandered for years. Eventually, they settled in Fez, then a center of learning, now a popular market on the edge of the Sahara. Here Maimonides, like most learned Jews of the period, studied medicine and religious philosophy. As the politics of Spain spilled across Gibraltar into the Moroccan desert the family moved east to Cairo after a brief sojourn in Crusader controlled Latin Jerusalem. At Fustat, near Cairo, under Saladin's competent administration the political climate was right for writing, study, medical practice and business success.

By this time Maimonides was thirty and, thanks to generous support from his prosperous father and younger brother, he had become a man of great learning. With their deaths, one in a shipwreck that carried away the family fortune, Maimonides decided to become a physician, rather than violate the Talmudic injunction never to make the Torah "a spade to dig with." His great skill and conscientious attention to his patients won him renown and he was appointed personal physician to the Sultan. So competent was he that a court poet wrote:

> "If the moon would submit to Maimonides art,
> He would heal her of her spots,
> Cure her of her periodic troubles,
> And keep her from ever waning!"

As court physician and the brother-in-law of one of Saladin's secretaries, Maimonides did enjoy the rewards of political and economic success; nonetheless, medical practice has a familiar and mundane ring as he describes it . . .

> "I live in Fustat while the king resides in Cairo at a distance of two permissible journeys on Sabbath (about three miles). My duties at the royal court are very exacting; I must see the king every day. But if he feels unwell, or if one of the children or concubines falls ill, I must spend most of the day at the royal palace in Cairo. Similarly, if one or another official is sick, I must attend to his medication . . . In any case, I do not return

home before noon, quite hungry (and exhausted). But I find my waiting rooms filled with people, Jews and Gentiles, distinguished and common, judges and surveyors, friends and enemies, a mixed multitude awaiting my return."

In the theocratic state, whether Muslin or Christian, the Jew has always had a special problem. His is a religion of the highest law. To disobey his religious tenets was to violate the law of man. At times the secular law demands an accommodation with religious precept. In an open society the problem is minimal. In a tolerant theocracy two systems of justice must work side by side. With despotism the result is holocaust. In Saladin's empire tolerant government allowed Maimonides to rise to the posture of a brilliant jurist since not only medicine but law as it applied to a Jewish society became his concern. His counsel was sought from Arabia to France in delicate and difficult matters of Jewish law. His greatness lay partly in his phenomenal capacity to amass knowledge but mainly in his wisdom as he sifted and assayed that knowledge. Trained in the Arabic world of the 12th Century, he knew well Hippocrates, Galen and Aristotle both in Greek and his native Arabic. The system of healing provided by Hippocrates, the anatomy of Galen and the mechanistic philosophies of Aristotle were all dealt with by Maimonides in interpreting the Mosaic law, the old prophets and the later Talmudists to adjudicate the lives of medieval Jews. In his *Guide for the Perplexed,* Maimonides states his position:

"The general object of the law is twofold: the well-being of the soul, and the well-being of the body. The well-being of the soul is promoted by correct opinions communicated to the people according to their capacity. Some of these opinions are therefore imparted in a plain form, others allegorically; because certain opinions are in their plain form too strong for the capacity of the common people. The well-being of the body is established by a proper management of the relations in which we live one to another. This we can attain in two ways: first by removing all violence from our midst; that is to say, that we do not do every one as he pleases, desires and is able to do; but every one of us does that which contributes towards the common welfare. Secondly, by teaching every one of us such good morals as must produce a good social state. Of these two objects, the one, the well-being of the soul, or the communication of correct opinions, comes undoubtedly first in rank, but the other, the well-being of the body, the government of the state, and the establishment of the best possible relations among men, is anterior in nature and in time."

He was the confirmed rationalist, startlingly contemporaneous in his ability to resolve Aristotle, Genesis and the prophets. While rejecting the tales of Genesis as allegory for the sake of instruction, he also rejected the purely mechanistic concepts of the origin of the Universe as espoused by Aristotle. Since universal origins are unknowable by the simple mind of man; faith in the divine influence is as intellectually acceptable as the theory of the inevitable interaction of mechanical forces suggested by Aristotelean logic.

A rational man with a sense of reason must state as Maimonides did that whenever reason was absolutely certain of its findings the contradictory statements in the Bible must be explained in an allegorical way, by searching out their hidden rather than their literal meaning.

Maimonidean philosophy rejected the anthropomorphic view of the deity. Man in God's image had to be examined by the use of homonyms to search out the true or hidden meaning of the God-man concept. For example, the classical statement of the Hebrews that God is One could mean there is but one God or it could mean God is unique and there is none like Him (including man!).

In relating God to the Universe, the sage felt that the revelations of the incorporeal God through miracles can be rationally accomplished by an omnipotent power that could alter the laws of nature which were of His own creation. Such breaches of natural law were not reversals but temporary adaptations to achieve a specific purpose. Reason allows for gifts of prophecy as well in order for the word of God to be communicated to man.

Despite a brief Inquisitional attempt to destroy his work, an enlightened Pope later promoted a Latin translation of his *Guide for the Perplexed,* and Christian scholastics such as Al-

bertus Magnus and Thomas Aquinus cited "Moses the Egyptian," with approval and respect. Some historians consider his "Guide" the inspiration and forerunner of the "Summa Theologica" of St. Thomas.

From Fustat just outside Cairo came a Codification of Judaic Law where reason takes up its marriage with scripture in an eternal honeymoon. That Codification survives today as the foundation of modern Judaism. It provides a climate of reason in a religion where a physician can practice his art in harmony with his God and maintain his faith in both.

The words of Judah Halevi, another Hispanic-Jewish Medieval philosopher and poet, who was himself a physician, sum up for a modern the faith he must have in himself, his art and his God . . .

My medicines are of Thee, whether good
Or evil, whether strong or weak.
It is Thou who shalt choose, not I.
Of Thy knowledge is the evil and the fair.
Not upon my power of healing I rely;
Only for Thine healing do I watch.

Dr. Hodes, 238 East Davis Boulevard, Tampa 33606.

What Parents Can Do About New Marriage Styles

Jose J. Llinas, M.D.

On a recent trip to New York, a dear old friend and colleague asked me a poignant question. Since then as I talk to other people, particularly those with children of marriageable age, variants of the same inquiry surface like a dark submarine out of muddy waters.

In many years of psychiatric practice, similar perplexities from distraught parents have come up.

"What," my friend asked, "have we done wrong as parents?" He prefaced the question by the remark that he had felt, throughout the years, he had had a reasonably open and friendly relationship with his children; that he and his wife had generally agreed and worked together in matters of discipline and guidance, and that he had always thought of his family life as warm, rich and understanding.

What happened to change his perception?

"I just found out," he said, "that my oldest boy's girlfriend, who is only 16, has been getting contraceptive pills from a so-called free clinic here in town."

After the initial shock, he said he was very angry, and called his lawyer with the purpose of suing the clinic, he wasn't clear about what. Fortunately, the lawyer very wisely advised a cooling off period and even more perceptively asked if he had discussed the problem with the young people involved.

"I began to realize that perhaps I was overreacting, as otherwise the idea would have occurred to me. I must confess even after that I did not really relish the assignment. I was brought up to think that sex is a personal and intimate thing and despite all my training and experience, and even my ability to help patients with sexual problems, I wasn't quite sure how appropriate this area might be in my role as a father."

With his wife's support, however, they both proceeded to talk to the young couple. They were prepared, I gather, for expressions of doubt, insecurity, even perhaps a certain amount of tearful remorse. But they were confronted with, from their traditional standpoint, an even more shocking reaction.

The young people involved were not at all disquieted by the disclosure.

Yes, the girl had been on the pill for several months. No, they did not see anything wrong with their attitude. They care a good deal for each other, in fact, they hope to be married some day and they see no sense in waiting, as the Victorian novelists put it, "to consummate their love." No, they don't agree, though they said they understood and respected their parents' moral values; they just did not share them.

"When my wife started crying, would you believe it, they were very supportive. But they feel their values are different. And, here is the hooker, they tried to convey to us the idea that we, as parents, had done nothing wrong. It is just a different value system for them."

Changing Relationships

"For those of us now middle-aged," Eda J. LeShan explains in a recent publication,[1] "with children in their late twenties, it is alarming to see our children moving away from the patterns of courtship and marriage which we were taught were the basis for personal fulfillment and social stability."

And, while we are still thinking in terms of legal mates, the younger generation seems to be going in the direction of both mates and roommates, on the basis of personal commitment, rather than traditional or legal or religious formulas.

"The roommate Judy brought home from college," as a distraught mother put it, "was the wrong sex, the wrong religion, even the wrong color!"

To young people, and more and more to many people at large, regardless of their age, there is

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something outrageous and asinine about statements of that sort. Times have changed, or perhaps more appropriately, they are changing, with action and reaction creating a good deal of turmoil.

Too Much Permissiveness

The pendulum might have swung too far and, in my experience, it is not only the middle-age group who is chagrined and confused. Many young people are also uncertain and uncomfortable in an atmosphere of excessive freedom, for which they are not ready.

"When social change is so rapid, and society so complex." Dr. Le Shan goes on, "how can parents and young people find their way? Must the young go it alone because parents are too tied to the past to be of any help? How can young adults choose ways of living and loving that will be meaningful and satisfying?"

She points out that, if we look candidly at the traditional forms of marriage, we can see that while marriages were relatively stable and permanent, they were also frequently unhappy.

When divorce was pretty much out of the question because of economic and religious and social pressures, there were marriages in which people (a) *exploited* each other, (b) *destroyed* each other's lives, and (c) simply *tolerated* each other's existence.

All of us know, and it is equally clear to our youngsters, that there are married couples whose relationship can best be described as quiet despair; many others are in a constant state of civil warfare.

Now that divorce has become more acceptable, there are upwards of 10 million American families in which the husband or the wife have been married before.

Alternate Life Styles

There is no question that many young people, dissatisfied with traditional relationships, are honestly searching for what they feel is a better way to relate to one another.

"Most of the young persons, earnest about life and love, who are searching for new life styles," Dr. Le Shan concludes, "are involved in what may be viewed as trial marriages."

As the number of experimenters increases, their impact and visibility become greater and many more people are encouraged to follow their example.

A much smaller group of young people, and in fact people of different ages and backgrounds, are trying out variants of communal life. One contemporary psychiatrist in England attempted to use communal living as a solution to psychotic episodes. Very clearly behind those attempts emerges a desperate hunger for human contact, love and understanding. But the reason that, throughout a period of years, most communes including those founded by the British psychiatrist end in disaster is that no artificial social experiment provides quite the same affectionate rewards as the natural family. It is as though somebody tried to produce huge raw natural diamonds in the laboratory with only the tools of the 15th century alchemy to help.

Aberrations of these, the newest of social forms, can produce as horrifying and bizarre a result as the so-called "Manson family" in California.

Odds Against

Another reason for failure is that it is usually people who somehow do not make the grade in traditional society who attempt the, in many ways higher, challenge of trying to succeed in a new and more complicated way of relating.

It is as though one failed high school but felt that it would present no problem to go to medical school.

One has difficulties trying to develop a satisfactory, growth-oriented relationship to another single human being but somehow one feels that relating closely to several other different human beings in a similarly close situation will be easier.

Perhaps many times, instead of representing escapism or immaturity, going to live in a commune may stand for deep idealism, a genuine concern for others and a loving and trusting way of learning about oneself and other people.

But, how can we tell?

What Parents Can Do

The role of parents, which my friend and so many others find a hard one nowadays, involves some ability to tell the difference and if possible help the younger generation recognize it too. It obviously would be too late to start worrying about the problem when a child is 17, and that is probably the most common mistake we make as parents. Children begin their training in human relationships very early. If at home things

are more important than people, a youngster knows.

When we see family responsibilities as a great burden and we run away from home interaction by going to the hospital at all hours, because clearly we are indispensable, a child realizes it. If we have no fun practicing medicine; if very few other things in life spark our interest; if we look past our loved ones, little people have no need for us to draw them a map.

Is there no helpful advice we can give parents, then, if, like my friend, they are convinced they missed the boat somewhere?

Of course there is. The fact remains that it is never too late to try to correct a mistake or rebuild a relationship that went astray somewhere. We can always admit our perplexity, without blaming either ourselves or our children; we can try to listen and to be more objective about our strong biases, which take a lifetime to firm up. We can refrain from censure and instead comment in a good and friendly manner. We can say, "I am not sure I understand what you are doing or why but I will try to stand by you as best I can, and hope things will become clearer both to you and to me." In other words, when confronted with problems of this type, a constructive attitude is one of the best alternatives.

As time goes on another consolation appears for as the young people grow older and mature, the attitudes they found so revolting in their elders creep up inside their own souls. And by then, many times they have their own children to contend with!

Reference

1. Le Shan, Eda J.: Mates and Roommates: New Styles in Young Marriages, Public Affairs, New York 1972.

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1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

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3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

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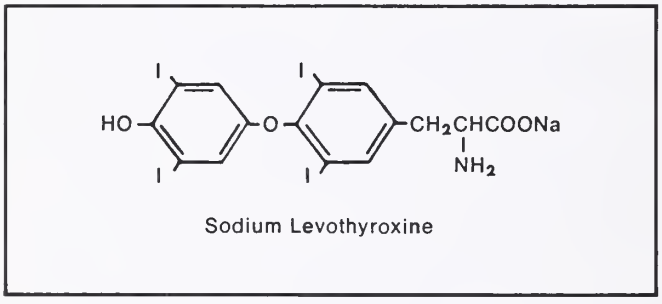

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Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets**, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

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Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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*U.S. Pat. 2,889,363

ORGANIZATION

William Monroe Rowlett Jr., M.D.
(1884-1975)

The life of William Monroe Rowlett Jr., M.D., was replete with superlatives.

—He was captain of the University of Florida's first football team in 1905, when that institution was domiciled at Lake City.

—When he began medical practice in Tampa five years later he was that area's first specialist in obstetrics and gynecology.

—And at the time of his death, July 28, 1975, at the age of 91, he was the oldest living past president of the Florida Medical Association.

Dr. Rowlett was barely settled in practice when he began to discover that Florida was "a hotbed of medical crooks" as he would describe it many years later. He thus became intimately involved with exposing a bogus diploma and license racket that existed in Florida at that time.

"The exposure shocked organized medicine of America," he recalled in a letter to FMA 15 years ago last month. "You cannot conceive how deplorable the situation was."

Dr. Rowlett's quack-busting career was launched officially in 1914, when then Governor Sidney Catts appointed him one of the seven members of the old "regular" Board of Examiners. The Board met at Palatka on August 3, 1914, elected Dr. Rowlett its Secretary-Treasurer, and decided to focus its attention on the prosecution of illegal practitioners.

In those days, Florida had in addition to the "regular" board an eclectic board and a homeopathic board. Dr. Rowlett and his "regular" colleagues were disturbed by the activities of the eclectics.

They served without pay and earmarked examination fees for a fund to prosecute illegal practitioners. The Board hired detectives and attorneys. Soon a large file of evidence was being accumulated, and the regulars began to prosecute their cases in state courts. Although the regular board was able to establish that eclectic licenses had been issued to foreign nationals before they even came to the United States, case after case was lost.

Disappointed but undaunted, the regulars took their evidence to the U.S. Justice Department in Washington. Two FBI agents and a postal inspector were speedily dispatched to Tampa to evaluate the evidence.

"As Secretary of the regular Board, I frequently travelled with the FBI men in order to interpret medical terminology," Dr. Rowlett recalled later.

The crusade struck paydirt in the spring of 1921, when the eclectic board secretary, Dr. G. A. Muench, and a dozen physicians he had licensed were indicted for mail fraud. The ensuing trial drew reporters from some of the nation's leading newspapers, and several officers of the American Medical Association converged on Tampa for the duration.

Muench and several of the eclectics indicted with him were convicted, and Muench was sent to federal prison in Atlanta, where he died.

With Dr. Rowlett wearing two hats—as Secretary of the regular board and as FMA legislative chairman—the Florida Legislature, reacting to the scandal, established a composite Board of Medical Examiners in 1921.

Dr. Rowlett was named Secretary of the composite Board, and between that and the old regular board he served for 27 years without pay as secretary.

The Tampa physician's dogged and successful efforts against the eclectics no doubt were a major consideration in Dr. Rowlett's election as President of the Florida Medical Association in 1933, and his selection in 1962 to receive FMA's highest honor, the Certificate of Merit.

William Monroe Rowlett was born at Collierville, Tennessee, on May 17, 1884, the son of William Monroe and Eleanor Swift Rowlett. In his youth, the family moved to Manatee County, Florida. He enrolled at the University of Florida, where he was captain and tackle on the school's first football team, and received his B.S. degree in 1906.

Less than three years later he had his medical degree from Emory, and he stayed in Atlanta for internship and residency training at Presbyterian Hospital, establishing his practice in Tampa in 1910.

In 1915, Dr. Rowlett served as Secretary of what is now the Hillsborough County Medical Association, but it was not until 1949, long after he had gone through the chairs of the Florida Medical Association, that he became President of his county society. During two periods of his life he served on the FMA Board of Governors, 1932-34 and 1945-51.

Dr. Rowlett's memberships, affiliations and honors are a litany of professional and civic attainment. He was: an organizer and director of Blue Shield and Blue Cross of Florida (1944); a charter member of the South Atlantic Association of Obstetricians and Gynecologists (1937) and the Southeastern Surgical Congress (1932); member of the State Executive Committee of the American College of Surgeons; member of the Advisory Committee to the University of Florida's J. Hillis Miller Health Center; and a member of the American and Southern Medical Associations.

He was a former President of the Tampa Kiwanis Club and the Hillsborough County Boy Scouts. For 30 years, he was Chairman of the Tampa Park Board, and Rowlett Park there was named in his honor.

He was a volunteer physician in World War I, and in World War II, his work with the Selective Service System earned him presidential citations from Presidents Roosevelt and Truman.

The list goes on and on.

His wife, the former Gregory Walker of New York City, whom he married in 1913, died several years ago.

Survivors include a daughter, Mrs. Harry P. Baya; two granddaughters; two sisters; a brother; and 14 nieces and nephews.

Lester Reynold Dragstedt, M.D.
(1893-1975)

Lester Reynold Dragstedt, M.D., internationally renowned surgeon and one of only four honorary members of the Florida Medical Association, died near Rapid City, Michigan on July 16. He was 81.

Dr. Dragstedt joined the University of Florida College of Medicine in 1959 as research professor of surgery after retiring from the University of Chicago.

His distinguished career included the development of vagotomy, a surgical technique which has provided relief for thousands of patients with duodenal ulcers. In Chicago, 20 years ago, he performed the first successful separation of Siamese twins in which both twins survived. He was the author or co-author of more than 400 scientific papers.

Dozens of special citations, honorary degrees and other honors have been bestowed upon him. Among them: the American Medical Association's Distinguished Service Award (1963); the Julius Friedenwald Medal of the American Gastroenterological Association (1964); honorary fellowship in the Royal College of Physicians and Surgeons of Canada (1965); the first Distinguished Service Award and Gold Medal of the American Surgical Association (1969); and the Royal Order of the North Star, bestowed by the King of Sweden in 1967.

A native of Montana, Dr. Dragstedt earned a Ph.D. degree from the University of Chicago in 1920, and his M.D. from Rush Medical College.

Survivors include the widow, Mrs. Gladys Dragstedt of Gainesville; two sons; two daughters; and 13 grandchildren.

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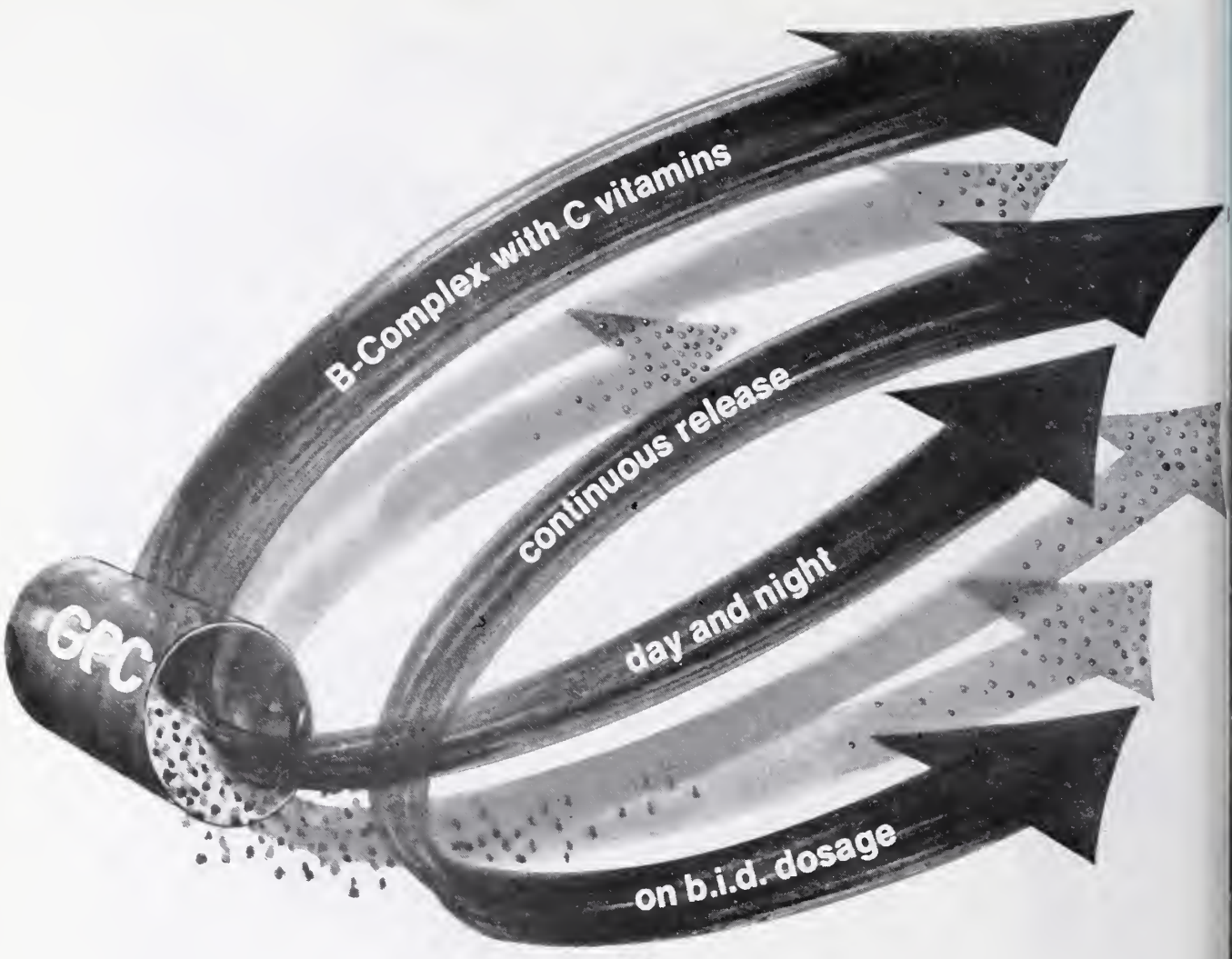

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und useful in the management of vertigo* associated with ses affecting the vestibular system.

n relieve nausea and vomiting often associated with vertigo.*

ual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

so available as Antivert (meclizine HCl) 12.5 mg. scored ts, for dosage convenience and flexibility.

ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for ea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

DICATIONS. Based on a review of this drug by the National Academy of nces—National Research Council and/or other information, FDA has classified indications as follows:

ffective: Management of nausea and vomiting and dizziness associated with ion sickness.

ossibly Effective: Management of vertigo associated with diseases affecting the ibular system.

inal classification of the less than effective indications requires further estigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

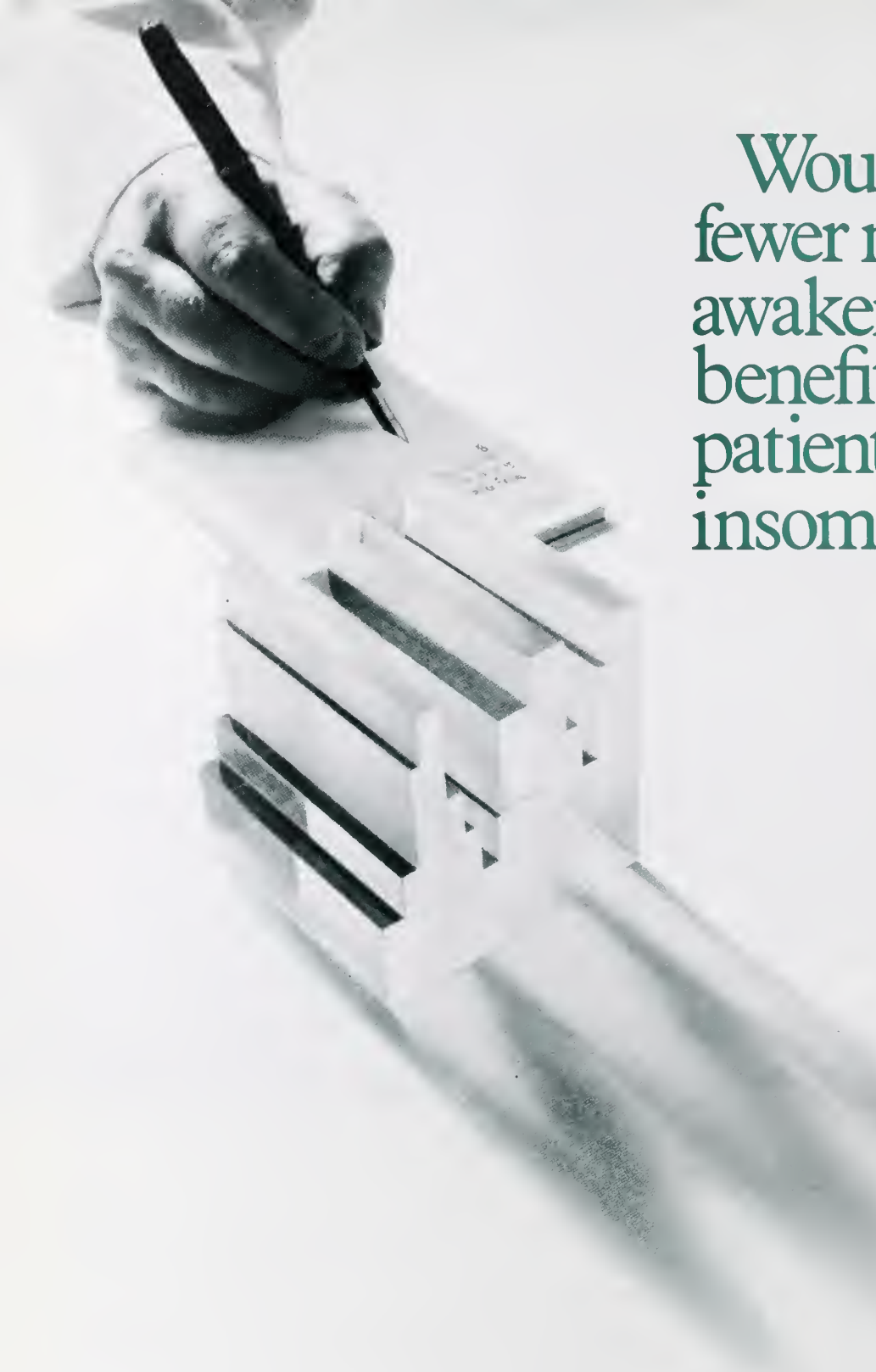
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



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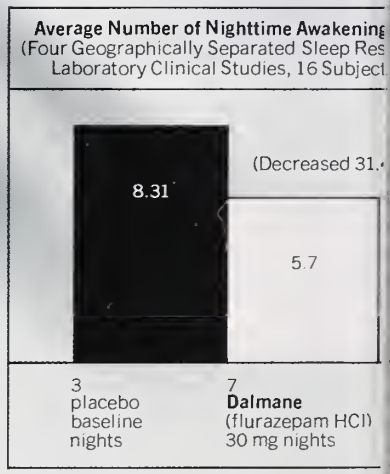

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ratory studies: on average,
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elatively safe, seldom
ses morning "hang-over"...

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al adult dosage is 30 mg *h.s.*,
with elderly and debilitated
ents, limit the initial dose to
ng to preclude oversedation,
iness or ataxia. Evaluation of
sible risks is advised before
scribing.

ERENCES:

racan I, Williams RL, Smith JR: The laboratory in the investigation of sleep sleep disturbances. Scientific exhibit at 24th annual meeting of the American hiatric Association, Washington DC, 3-7, 1971

ost JD Jr: A system for automatically vzing sleep. Scientific exhibit at the annual Clinical Convention of the rican Medical Association, Boston, 29-Dec 2, 1970; and at the 42nd annual ntific meeting of the Aerospace Medical ciation, Houston, Apr 26-29, 1971

gel GW: Data on file, Medical Depart-t, Hoffmann-La Roche Inc., Nutley NJ

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re prescribing Dalmane (flurazepam), please consult complete product rmation, a summary of which follows:

cations: Effective in all types of insomnia acterized by difficulty in falling asleep, uent nocturnal awakenings and/or early ning awakening, in patients with recurring mnia or poor sleeping habits; and in e or chronic medical situations requiring ul sleep. Since insomnia is often transient intermittent, prolonged administration is erally not necessary or recommended.

traindications: Known hypersensitivity urazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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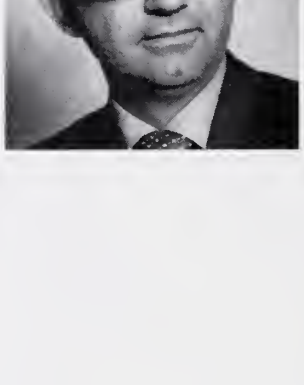
Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called pati
package insert has been around
a long time. Many physicians alr
use written instruction sheets to
provide patients with informatio
about the drugs they are taking.
some physicians give verbal inst
tions; but in too many instances
these are what I call eye-glazing
ercises. I have seen patients sit
glazed eyes listening to a rapid-f
lecture by a hurried physician w
has 20 people out in his waiting
room. These patients aren't give
sufficient understanding and th
fore do not follow instructions. S
think the idea of an official pack
insert for patients is a good one.
Perhaps we should really think c
this kind of information simply a
extension of drug labeling.

The benefits of patient involveme

Many physicians may not r
ize how frequently a patient obta
his drug information from Aunt
Tillie or the next door neighbor.
this information is almost alwa
bad or irrelevant to the case at h
Furthermore, the incentive to go
along with a prescribed program
slim if the only reading matter t
patient receives, along with his
scription, is a bill.

As an educator I am impre
by the principle that the best wa
get someone to do something is
involve him in the process. So th

I think there are advantage
well as some real disadvantages
a patient package insert. When
begin to use semi-medical or m
cal terms to describe complicat
or possible sequelae of disease
treatment, you may frighten the
tient—particularly since the mo
highly sophisticated patient is n
the one who is going to read the
sert. The patient who will read it
the one most susceptible to frig
and confusion by the language.

On the positive side, a pac
insert will probably give the pat
better insight into why he is bei
treated the way he is, and it may
give the physician a little bit mo
time. But it does not remove fro
the physician the need or obliga
to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should
warned of the possibility of seri
side reactions—to know what th
real dangers are. But it doesn't
bit of good to indicate that a pat
on oral penicillin may develop a
rash, itching, or a drop in blood
pressure. Or that he may faint.
think the real danger is that frig
engendered by the insert may p
sibly outweigh the potential goo

ain purpose of drug information the patient is to get his cooperan in following a drug regimen.

eparation and distribution of tient drug information

We would hope to amass infortion from physicians, medical cieties, the pharmaceutical indus- and centers of medical learning. e ultimate responsibility for uni- m labeling must, however, rest h the Food and Drug Administran. There is nothing wrong with s agency saying, "this informan is generally agreed upon and erefore it should be used," as long our process for getting the infortion is sound.

Distribution of the information a problem. In great measure it uld depend on the medication in estion. For example, in the case an injectable long-acting progesone, we would think it mandatory issue two separate leaflets—a ort one for the patient to read be- e getting the first shot and a long e to take home in order to make a cision about continuing therapy. this case, the information might put directly on the package and t removable at all. But for a mediion like an antihistamine this ormation might be issued sepaely, thus giving the physician the ion of distribution. This could serve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we hhold any information from the tient because, first of all, it would totally dishonest and secondly, it uld defeat the very purpose of the sert. I do think that a patient on the th control pill should know about e incidence of phlebothrombosis.

If you're going to tell a patient e incidence of serious adverse retions, then you have to tell him at a concerned medical decision s made to use a particular mediion in his situation after careful nsideration of the incidence of mplications or side effects.

notionally unstable patients pose special problem

There are patients who, beuse of severe emotional problems, uld not handle the information ntained in a patient package inrt. Yet if we are going to have a ckage insert at all, we just can't ve two inserts. I think we might mply have to tell the families of ese patients to remove the insert om the package.

gal implications of the patient ckage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

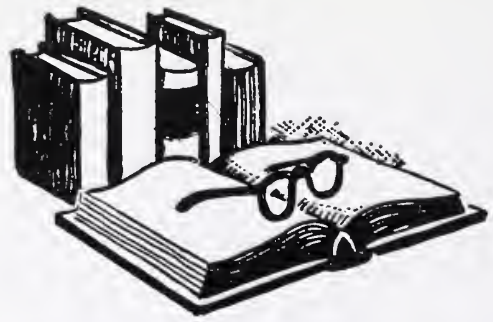
The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



Book Reviews

Emotional Issues in the Lives of Physicians by John C. Duffy, M.D. 92 pages. Price $6.50. Springfield, Illinois, Charles C. Thomas Company, 1970.

A column in the Medical Tribune of November 21, 1973 sent me to this book. Duffy quotes a study of physician's wives admitted to a private mental hospital over a 10-year period. In that study by Dr. George T. Harding of Ohio State University, the situations leading to the need for psychiatric care and treatment were a failure of "double dependency."

An example of double dependency failure is as follows: The girl sees the young physician or medical student as kind, helpful, giving, and understanding. She believes that her physician-husband will meet all her emotional needs. The author points out that this is common in a nurse-physician marriage with young physician responding to the efficiency and competence he sees in the nurse. "In some of these nurse-doctor marriages, this role confusion continues after marriage, with each partner expecting strength, guidance, direction, and support—something they thought they saw in each other, but which actually existed only in fantasy or perhaps in the hospital setting, which was not transferable to the home."

The author points out that after marriage many of the physician's emotional needs are met outside the home "but his wife may be seriously deprived of the tenderness and undivided attention for which she in fact married him."

In Dr. Harding's study of physician's wives in the private mental hospital, half of these studied admitted using medications in excessive amounts. Many of these patients received the medication from the physician-husband. The reasons given by the physicians for prescribing medications for their wives were "I put her off until I finally had to get some sleep"; "She is more forceful than I am"; "I gave it to her to save me social embarrassment"; "I'll give her anything to keep her happy and off my back."

Not to leave the physician-patient out, Dr. Duffy discusses studies which he has made on physicians requiring hospitalization for psychiatric treatment.

"Demands of family and the society seem to overwhelm these physicians. They often felt that they must be all things to all people—patients, colleagues, wife, children, and community. Their involvement in their profession frequently became an escape for the painful realities of their lives. The destructive pattern of long hours, no outside interests, no time for family life or vacations, as well as many other longstanding unhealthy life attitudes were all too evident among these physicians. Then inordinate need for prestige and power associated with poorly controlled aggressive and hostile drives led inevitably to professional and emotional disaster."

Dr. Duffy quotes Emily H. Mudd, Ph.D., Director of the Marriage Council of Philadelphia, writing in a Medical Economics symposium as follows: "The average doctor spends far too little time in selecting a marriage partner, and considering what marriage will mean to him in terms of his future work. . . . He is most likely to be looking for a mate while he is still a medical student, an intern, or a resident. So his time is compressed, and his contacts are rather limited. This, plus a tendency to seek a supportive type, helps to account for the fact that one-fourth of the doctors' wives surveyed in this article turned out to be nurses.

"Then there is the young man who enters medical school having already established a relationship with the girl back home. He may even have gone to high school or even to a local college with her. The difficulty here is that she may stop developing intellectually while he goes on to become much more sophisticated. She may not have the opportunity or capacity to grow apace. After they're married, the doctor expects something of her she can't deliver. If she is a prom type girl—an egotist who needs adulation, she's in for a shock when she finds herself married to a man whose patients adore him, not her."

If there is a lesson to be learned from this chapter in a brief monograph, it may be that physicians and wives must see themselves and each other as human beings. They must work at relationships with time, care, and nurture as other persons must. The problem of the physician treating members of his own family should need no reemphasis.

One of the limitations of this monograph is its lack of formal references. Although partial references are given in the text, it would be difficult to locate the articles which the author quotes. Many of the points made by Dr. Duffy have been made before. However, if one wishes to have assembled in the pages of a small publication, chapters covering stresses on physicians, this may just be the monograph for you.

F. Norman Vickers, M.D.
Pensacola

George III and the Mad-Business by Ida Macalpine and Richard Hunter. 407 pages. Price $10.00. New York, Pantheon Publishers, 1969.

It seems appropriate, as the United States approaches its bicentennial year, to review this well-researched book on "mad" King George III's illness. The authors present convincing evidence that the king's illness was in actuality acute intermittent porphyria. His sixty-year reign, from 1760 to 1820, which included the loss of the American Colonies, had impacts on the Empire as well as on the course of British medicine. His first attack occurred in 1765 at age 26. His attack of 1788-89 in which his mental derangement had political repercussions caused the British leaders, including physicians, to reconsider the problem of treatment of the mentally ill.

The authors, both English psychiatrists, first published their works in two articles in the British Medical Journal in 1966 and 1968. King George III's physical symptoms, suggesting acute intermittent porphyria and intermittent discolored urine, were documented. A family tree going back to Mary, Queen of Scots, 1542-87, is presented. It is interesting that Mary's son James VI, 1566-1625, was said to have passed discolored urine on numerous occasions. The authors point out that the appearance of the urine in those days, 200 years prior to King George III, had major significance for the " 'piss prophets' who divined everything from it."

A section of this book is devoted to the impact of the king's illness on the medical practice. Of particular regard to me was the discussion of the conflict-of-interest physicians were caught up in by owning private madhouses.

F. Norman Vickers, M.D.
Pensacola

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

General Ophthalmology, 7th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 335 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1974.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1957.

Human Sexuality in Health and Illness by Nancy Fugate Woods, R.N. with a chapter by James S. Woods Ph.D. 232 Pages. Price $6.95. St. Louis, The C. V. Mosby Company. 1975.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

How to Beat Fatigue by Linda Pembrook. 223 Pages. Price $6.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975

Problem-Directed and Medical Information Systems edited by Marshall F. Driggs, M.D. 241 Pages. Illustrated. Price $15.45. New York, Intercontinental Medical Book Corporation, 1973.

Review of Medical Physiology, 7th Edition by William F. Ganong, M.D. 587 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Review of Physiological Chemistry, 15th Edition by Harold A. Harper, Ph.D. 570 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1975.

Emergency Medical Care, edited by J. Clifford Findeiss, M.D. 333 Pages. Illustrated. Price $17.95. New York, Intercontinental Medical Book Corporation, 1974.

Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

PENSACOLA EDUCATION PROGRAM (PEP) . . . has expanded its program with the addition of training programs in family practice and in ambulatory and emergency room care.

PEP has retained Thomas Quehl, M.D., as full-time director of family practice, and Gerald Early, M.D., as director of the ambulatory and emergency room program. Legislative appropriations will be used to help support these programs.

ESCAMBIA COUNTY MEDICAL SOCIETY . . . Executive Committee has urged its members to contribute to the Prevost (Doc) Coulter Scholarshp Fund, named in memory of a prominent Pensacola newspaperman and friend of medicine.

The scholarship will be awarded to a student interested in journalistic career training at the University of West Florida. Coulter was the recipient of FMA's second Distinguished Layman award.

THE UNIVERSITY OF FLORIDA . . . will use a $585,527 Veterans Administration grant to fund a Bachelor of Health Science degree program for allied health personnel who have earned associate degrees.

According to Dean Howard K. Suzuki of the College of Health Related Professions, the program "is designed as a career link between the technician role and the educator or supervisor role." A class of about 15 students, including respiratory therapists, dental hygienists, nurses, radiologic technicians, physician's assistants, and others will begin studies in September.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE . . . has received a construction grant of $3,756,700 from the Department of HEW, the largest federal award the medical school has ever received. School officials said the money will cover about 70 per cent of the estimated current cost of building a Primary Care-Family Health Care Center near Jackson Memorial Hospital.

SOUTHERN MEDICAL ASSOCIATION . . . expects 5,000 physicians and other medical personnel to attend its 69th Annual Scientific Meeting at Miami Beach, November 16-19. The scientific program will include 19 postgraduate courses.

Information may be obtained from SMA, 2601 Highland Avenue South, Birmingham, Ala. 35205.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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Solar keratoses are generally not difficult to identify.

These skin lesions are usually multiple, flat or slightly elevated, brownish or red in color, papular, dry, rough, adherent and sharply defined. They are found on areas of the skin having extensive exposure to sunlight. Clinical characteristics of the lesions, their predominant location on exposed surfaces, the age of the patient and his skin type are important considerations in the diagnosis.

Solar keratoses can, and should, be treated because they are potentially premalignant.

Chronic exposure to sunlight frequently leads to degenerative changes in the skin. This can often result in the development of multiple, potentially premalignant keratotic lesions. Therefore, early detection and treatment is advisable.

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Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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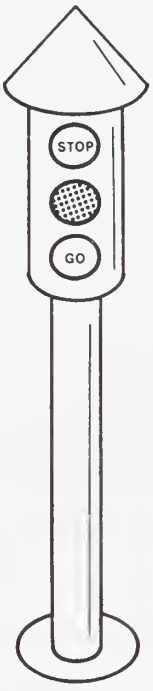

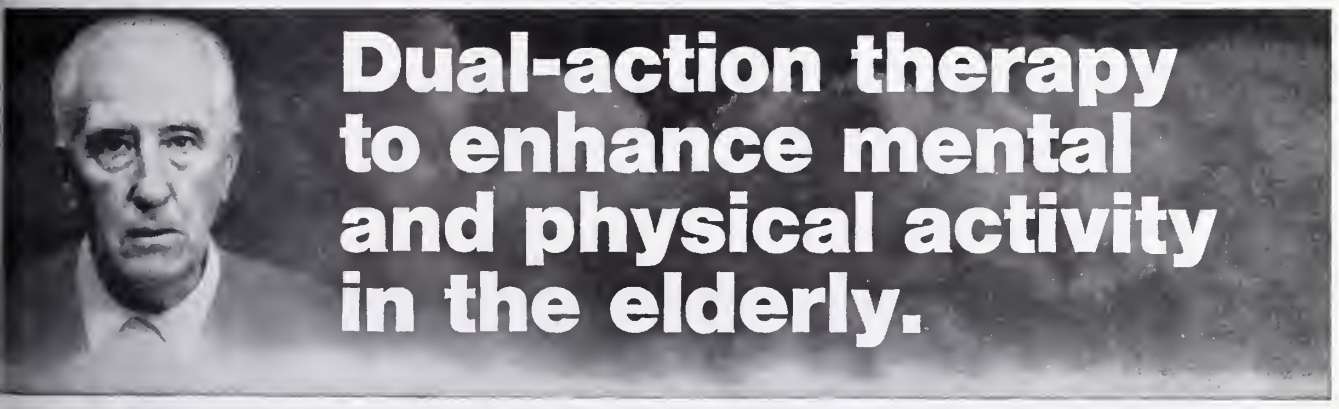

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PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.
CONTRAINDICATIONS: There are no known contraindications to Menic.

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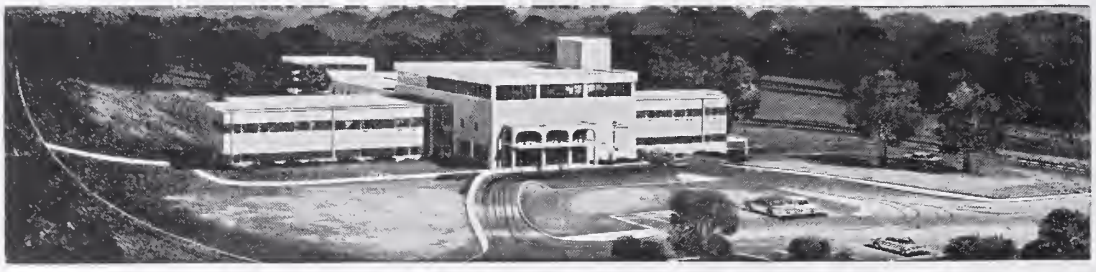

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Others Are Saying

An Incident In Pyongyang

Since I am an old soldier, you will have to indulge me as I tell an occasional war story.

In Korea in early December 1950, the troops of the Chinese People's Army were sweeping southward and threatening the North Korean capital of Pyongyang. We had just received a trainload of new M46 tanks. They sat on flat cars in the marshaling yards—like so many great squat toads. They were prizes that must not fall to the enemy.

Captain Will Baker of the 57th Tank Recovery Company was given the mission to unload the tanks and transport them south to safety. The northern sector of the city was already coming under enemy fire, and Will was given 24 hours to get them out. (Or the Air Force would be called in to blast them into uselessness.)

At about 6 p.m., soon after Captain Baker received the order, he rushed up and asked me for all the Dexedrine I had. I gave it to him: 40 packets, each containing three tablets of 5 mg each. They had been designed for just such emergency situations—to keep already exhausted troops awake and alert during periods of intense physical activity. I advised him to issue the packets to his men: single tablets to be taken only when they felt the tug of sleep or fatigue.

Well, the good guys won. Almost all the tanks were evacuated before Chinese mortar rounds began to thud into the marshaling yards. As I recall, the Air Force was called in to destroy only two tanks. It was well done; the courage and skill of Will Baker and the 57th became legend in the 8th Army (aided and abetted, of course, by my artfully conceived, skillfully administered therapy).

I told this story many times in the years following. It was the only true indication I had ever encountered for the use of amphetamines. (I did not treat hyperkinetic children, and I refused to give the drug to fat ladies.)

Well, about ten years later, Will and I were reminiscing—swapping the usual lies and tall tales—as old soldiers will. I recounted the terrible night in Pyongyang—the triumph of military bravura and medical science. Will took a deep drag on his briar and turned to me with a sheepish expression, "You know, Doc, I have a confession. The next morning when we were rumbling south, loaded to the eyeballs with those damned tanks, I reached into the pocket of my parka for a match. I found the forty packets of dexies."

So much for uncontrolled clinical trials.

But there is a point to be made. This incident is a more spectacular example of a recurring problem in clinical practice. Those of us who write prescriptions find it exceedingly difficult to evaluate the results of our therapy. This goes far beyond knowing bioavailability ratios and rates of metabolism and excretion. It gets down to the nitty gritty. Did the pharmacist interpret your handwriting properly? Did the patient understand the instructions on the label? Does little Mary with the diastolic rumble, who feels so fine, really take her penicillin twice a day? Does lawyer John with the diastolic pressure hovering around 100 remember to take his midday methyldopa? Did old George with the gouty nephropathy run out of money before he got his probenecid and allopurinol refilled?

It is an area beset with difficulties. Many times the patient is too embarrassed to admit, for one (always excellent) reason or another, he has not been following your orders. Some tend to tell hapless little lies, fearful of disappointing you or arousing antipathy.

In the presence of dramatic illness—especially one of acute onset (pulmonary edema, pneumonia, renal failure) where your therapeutic arrows fly to the heart of the target—there is little problem evaluating the effectiveness of treatment. But our problem resides in evaluating the long-haul management of disease—especially those with somewhat variable natural histories: hypertension, diabetes mellitus, gout, rheumatoid arthritis, chronic obstructive airway disease; one can think of dozens. So, I find it difficult to be dogmatic about the impact of my therapy.

Consequently, when I hear colleagues engaged in passionate debate—extolling the virtues of one drug and villifying another, I reflect on my own experience. I become uneasy: How can they be so much smarter than I?

Then I remember that cold night in Korea.

Reprinted from JAMA, December 17, 1973, published under the heading of "Ruminations" and written by JAMA Editor, Robert H. Moser, M.D.

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

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Deerfield, Illinois 60015

*See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Help stop the tears

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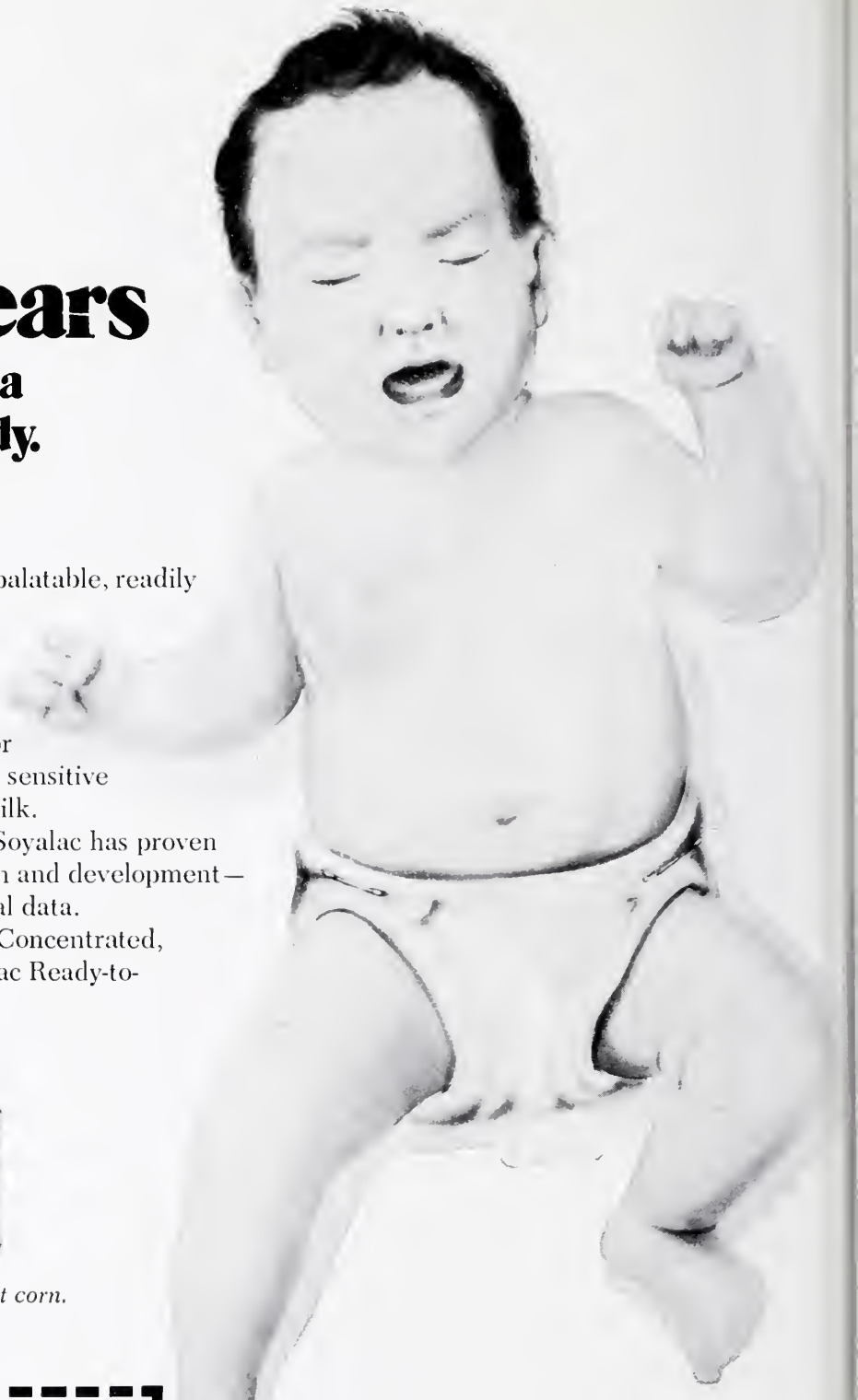

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Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

OUR PRESENT DEPARTMENT OF PSYCHIATRY is a three man department. We wish to double the size of this over the next three to four years. All candidates must be Board eligible. General psychiatrists or someone with subspecialty interests would be acceptable. Our department is a member of a multispecialty group located in Pensacola, Florida. Inquiries should be sent to W. M. C. Wilhoit, M.D., Chairman, Department of Psychiatry, The Medical Center Clinic, 1750 N. Palafox St., Pensacola, Florida 32501.

WANTED: Fully trained, board eligible-certified Obstetrician/Gynecologist to join two board-certified specialists, Florida Gulf coast, liberal benefits. Salary commensurate with ability leading to early partnership, corporate fringe benefits. Florida license required. Position available immediately. Respond immediately to C-693, P.O. Box 2411, Jacksonville, Florida 32203.

OBSTETRICIAN/GYNECOLOGIST: Attractive opportunity in north central Florida for private practice. Community has well-equipped, new 128-bed hospital with Ob/Gyn floor. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, P. O. Box 1989, Lake City, Florida 32055. Phone (904) 752-2560.

ORTHOPAEDIC SURGEON—FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

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MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Generous first year profit guarantee. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

WANTED: Female Obstetrician/Gynecologist to join two board-certified specialists, Florida Gulf coast, liberal benefits. Salary commensurate with ability leading to early partnership. Corporate fringe benefits, Florida license required. Position available immediately. Respond immediately to C-694, P.O. Box 2411, Jacksonville, Florida 32203.

PART TIME OR FULL TIME ORTHOPEDIC SURGEON NEEDED: In multi-specialty 20-man group in Aventura, North Miami Beach. Minimum guarantee is $25,000 with much more possible. This is a quality, fee-for-service group in private practice and it is not an HMO or Medicare clinic. Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180.

Miscellaneous

EMERGENCY ROOM PHYSICIANS needed for 99-bed community general hospital located in central Florida. Salary between $50,000-$60,000 per year. Florida license and membership in FMA required. Reply immediately to Vernon H. Bielefeld, Adm., Highlands General Hospital, P.O. Box 2066, Sebring, Florida 33870. Call (813) 385-6101.

PHYSICIAN DIRECTOR WANTED: General medical outpatient clinic. Progressive college community in central Florida. Excellent opportunity for the right person. Training in Family Practice or Internal Medicine preferred, Florida license required. Salary commensurate with training and experience. Contact: Raymond W. Wright, Administrator, Alachua General Hospital, Gainesville, Florida 32602; or call collect (904) 372-4321.

WANTED: Emergency room physicians to join newly formed group in Lakeland, Florida. Salary $20/hour, approximate 42 hour week. Contact Stephen Bourgeois, M.D. (813) 689-7623 or Paul Stein, M.D. at 644-1546.

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GATEWAY HOSPITAL — Florida's newest hospital in St. Petersburg, 301-bed now under construction, completion December 1975. 48,000 sq. ft. office space available December 1975 adjacent to hospital. ALL TYPES PHYSICIANS NEEDED. For further information contact Bernard L. Samson, Gateway Hospital Corp., 2600-9th St., N., St. Petersburg, Florida 33704. Phone (813) 822-8716.

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SEEKING EMERGENCY ROOM PHYSICIAN in 54-bed J.C.A.H. accredited hospital in small farming community on Lake Okeechobee. Both Florida licensed and foreign medical graduates will be considered. Contact C. Greig, Adm., Everglades Memorial Hospital, Box 659, Pahokee, Florida 33476. Phone (305) 924-5201.

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PSYCHIATRIST, board eligible, university trained, married, seeks to join partnership in private practice adult psychiatry Palm Beach County area. Write C-692, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Board certified Internist, age 32, subspecialty infectious diseases. Seeking hospital-based or large group practice. Available July 1976. Write C-689, P.O. Box 2411, Jacksonville, Florida 32203.

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real estate

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1976 FMA Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

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(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

- prompt and specific action
- documented benefit-to-risk ratio
- three dosage strengths to meet most therapeutic needs

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Roche Laboratories
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Nutley, New Jersey 07110

LIBRIUM®
chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

Please see following page.

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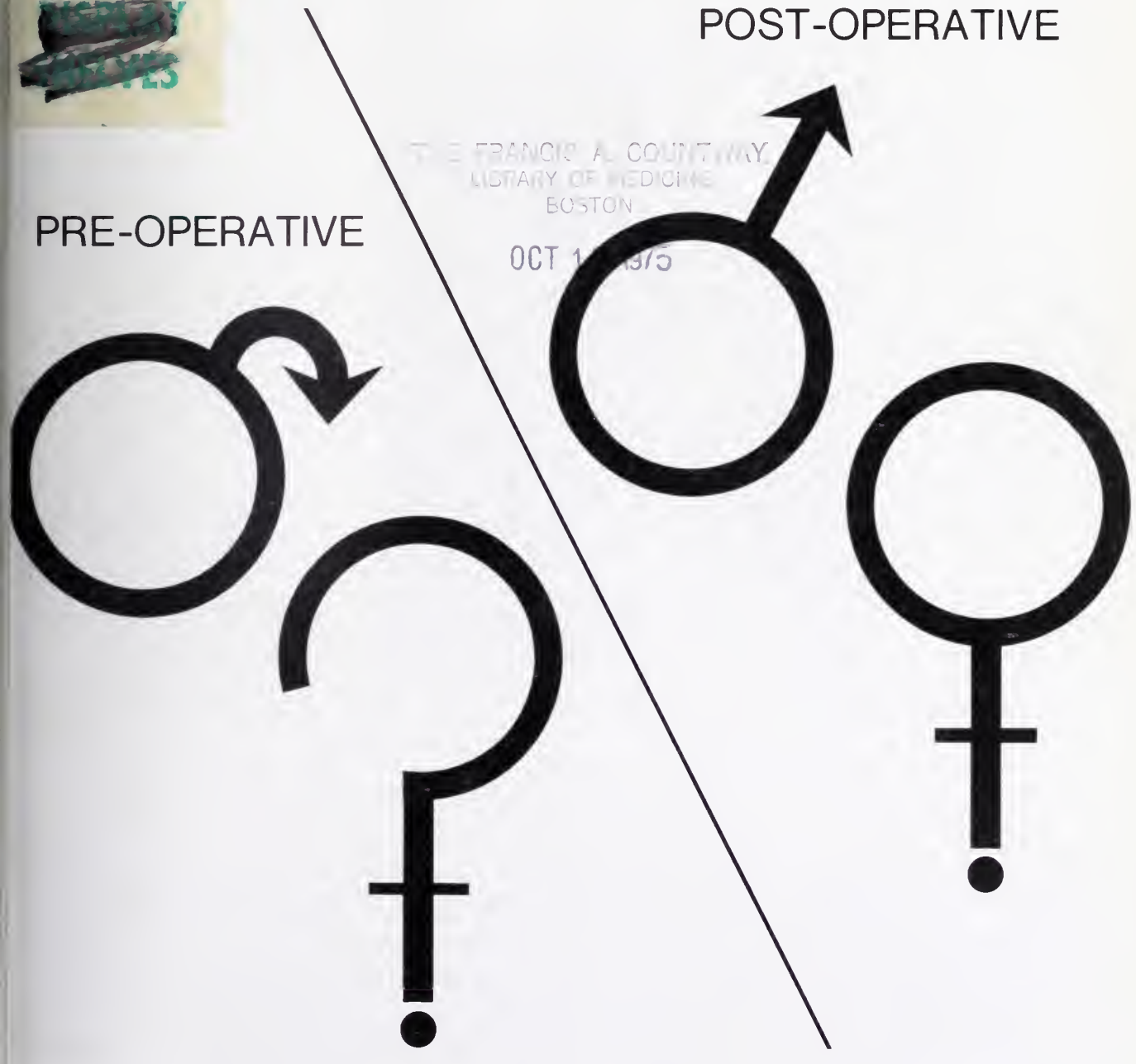

SURGICAL TREATMENT OF MALE IMPOTENCE

FMA'S PROFESSIONAL LIABILITY INSURANCE TRUST (See pages 5-7)

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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OCTOBER COVER — The cover represents the collaborative effort between Dr. John Snow and the Editor which symbolizes the lead article in this issue entitled "Penile Prosthesis — New Implant for Management of Impotence."

President's Page

FMA's Professional Liability Insurance Trust

I have asked our Executive Vice President, Dr. Harold Parham, to outline the salient facts concerning our professional liability self insurance trust following this page.

Some general statements seem indicated concerning the formation of this trust.

The physicians of Florida, including your officers, had no real desire to enter the professional liability insurance business. We did not support the concept of a joint underwriting association under the direction of the State Insurance Commissioner and viewed it as an emergency stopgap measure to offer physicians professional liability coverage if no other source was available. We have called upon the most knowledgeable professionals nationwide to search the free enterprise market for an available underwriter for our Association's program and found none. We were left two basic options to offer continued coverage to our membership. The first, to accept membership in the Joint Underwriting Association and the Patients Compensation Fund. The second, to form a self insurance trust under existing Florida Statutes. We have chosen the second option for several principle reasons, realizing the ultimate answers concerning professional liability insurance costs, legislative changes, consumer response, judicial attitudes, etc. are unanswerable at this time.

Your officers felt we had no other choice economically since published JUA rates were two and one half to three times Argonaut rates of January 1, 1975. These rates were intolerable to Florida residents and physicians and could only serve to escalate health delivery costs even more. The Patient Compensation Fund is accessible to physician members and therefore could serve as a bottomless financial trough to which *certain* lawyers and *certain* health consumers could look ad infinitum, again, raising health costs and ultimately adding these costs to the health consumer. Lastly, the first alternative would fractionate our membership and narrow our insurance base, again serving to elevate insurance premiums to physicians.

Therefore, we have chosen to form PIMCO (Professional Insurance Management Company) to manage our own self insurance trust.

For this venture to succeed, we obviously need certain fundamental happenings.

1.—Additional legislative changes offering significant financial relief to health consumer and provider alike during the coming legislative session.

2.—A broad base of enrollment and support from FMA membership without allowing ourselves to fractionate into smaller specialty, geographic, or other groupings which are utlimately destined to failure.

3.—A call for professional restraint from the overwhelming numbers of honest lawyers to the small minority of their profession who are encouraging and engaging medico-legal cases without merit and literally "choking the goose who lays the golden egg."

4.—A public realization that *their* dollars are really paying the medical liability costs and significantly altering the availability of proper health care at a sensible price.

We should all realize the wisdom of John Locke's words nearly a century before the Second Continental Congress that "Rulers hold their power not absolutely but conditionally, government being essentially a moral trust, forfeited if the conditions are not followed by the trustees."

Your Florida Medical Association "trustees" are holding the trust of the physicians of Florida. I pray the other human elements in this equation can do likewise.

Vernon B. Astler

Executive Vice President's Report

Professional Liability Protection

The FMA Professional Liability Insurance Trust, established, sponsored and endorsed by the Florida Medical Association was formally submitted to the State Insurance Department on September 4, 1975. There has been frequent consultation with this Department as the program was developed, particularly with Mr. Tom Brown, the Assistant Insurance Commissioner, who was most helpful, and an early approval is expected from the Department.

Untold hours have been spent and scores of knowledgeable individuals have been consulted in the evolution of this Trust. It should prove to be one of the finest mechanisms available to provide professional liability protection for members of the FMA.

Briefly, the Trust and its management company, PIMCO, will provide:

—$500,000 basic coverage, no aggregate (premium the same as Argonaut January 1, 1975 for $100,000). See Exhibit I.

—Umbrella coverage of $1 million for approximately 60% of the basic coverage premium.

—Annual protection coverage (claims made) with automatic premium payment of endorsement for extended coverage (occurrence basis) for death, disability, or normal retirement. Other members are subject to an additional premium or to a surcharge.

Members of the Trust will participate in the payment of up to a maximum of $5,000 for damages against them (20% of the damages for the first $25,000).

Forty percent of the first year premium will be placed in a security deposit account (in the physician's name) and if not needed for losses in 5 years may be returned with interest.

All participants must be reviewed and approved by their county medical society and the FMA to be eligible for membership in the Trust.

Centralized claims handling and legal coordination will be afforded this program and there will be an active defense of every unwarranted claim.

A risk management program will be established with adequate service offices in several geographical locations of Florida.

The initial FMA-PLI Trustees (Vernon B. Astler, M.D., Jack A. MaCris, M.D., James W. Walker, M.D., and Richard S. Hodes, M.D.) will place reserve and surplus monies in bank trust accounts, utilize Barnett Financial Advisors' services and PIMCO for management and insurance purposes.

Recognized C.P.A.'s will provide audits for each activity.

PIMCO's Board of Directors is comprised of outstanding insurance and business executives to direct its affairs. I will serve as President on behalf of the FMA until a permanent President is selected which is anticipated in the near future. (The Directors of PIMCO are W. E. Addy, J. Edgar Cowart, William H. Howard, Ph.D., Gordon T. Hubbard, Earl C. Trefry, and Bruce A. Woolery).

THIS COVERAGE WILL BE AVAILABLE UPON THE COMPLETION OF THE UNDERWRITING OF THE FIRST 1,000 PHYSICIANS (Subject to final negotiation for reinsurance and the umbrella policy). At the time of this writing mid or late October is anticipated.

I plead to each physician when he becomes a member of this Trust to pledge to ACTIVELY support the legislative program being developed by the FMA to curtail the spiraling cost of medical liability insurance and the need for increased premiums every year.

W. Harold Parham, D.H.A.

Exhibit I

FMA PROFESSIONAL LIABILITY INSURANCE TRUST

PROPOSED ANNUAL PREMIUMS FOR PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY PROTECTION

EFFECTIVE OCTOBER 1, 1975

	$500,000 EACH CLAIM No Aggregate Limit	
	Dade and Broward Cos.	Remainder of State
1. BASIC CHARGES:		
1. Physicians—No surgery	$1,313.00	$ 814.00
2. Physicians—Minor surgery and assisting in major surgery on own patients	2,284.00	1,430.00
3. Surgeons—General Practitioners who perform major surgery or assist in major surgery on other than their own patients, and Cardiologists (including catheterization but not cardiac surgery) Ophthalmologists and Proctologists	4,949.00	3,099.00
4. Surgeons—Cardiac surgeons, Otolaryngologists (no plastic surgery) General Surgeons, Urologists and Vascular Surgeons	6,583.00	4,128.00
5. Surgeons—Anesthesiologists, Neurosurgeons, Obstetricians—Gynecologists, Orthopedists, Otolaryngologists (including plastic surgery) and Plastic Surgeons	8,243.00	5,148.00
6. Emergency Room Physicians	2,284.00	1,430.00
Partnership or Professional Association Surcharge	20% for Each Physician	

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estroge Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estroge complex in the proportions foun in its natural source. And for mor than thirty years PREMARIN ha enjoyed an unparalleled record o clinical efficacy and acceptance.

PREMARIN. The only estroge preparation available that contai natural estrogens exclusively and a meets all U.S.P. specifications fo conjugated estrogens. Assurance quality for you and your patients **PREMARIN . . . naturally.**

RIEF SUMMARY
or full prescribing information, see package cular.)
REMARIN®
onjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

ntraindications: Short acting estrogens are ntraindicated in patients with (1) markedly paired liver function; (2) known or suspected carcinoma of the breast, except those cases of gressing disease not amenable to surgery or adiation occurring in women who are at least ears postmenopausal; (3) known or suspected rogen-dependent neoplasia, such as carcima of the endometrium; (4) thromboembolic orders, thrombophlebitis, cerebral embolism, in patients with a past history of these conditns; (5) undiagnosed abnormal genital bleeding.
rnings: Estrogen therapy should not be given women with recurrent chronic mastitis or abrmal mammograms except, if in the opinion of physician, it is warranted despite the possibil- of aggravation of the mastitis or stimulation undiagnosed estrogen-dependent neoplasia.
The physician should be alert to the earliest nifestations of thrombotic disorders (thromphlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

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CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

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EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg.
Methyltestosterone	1.25 mg.
L-lysine	100 mg.
Nicotinic Acid	12.5 mg.
Iron (from Ferrous Sulfate)	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific. Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

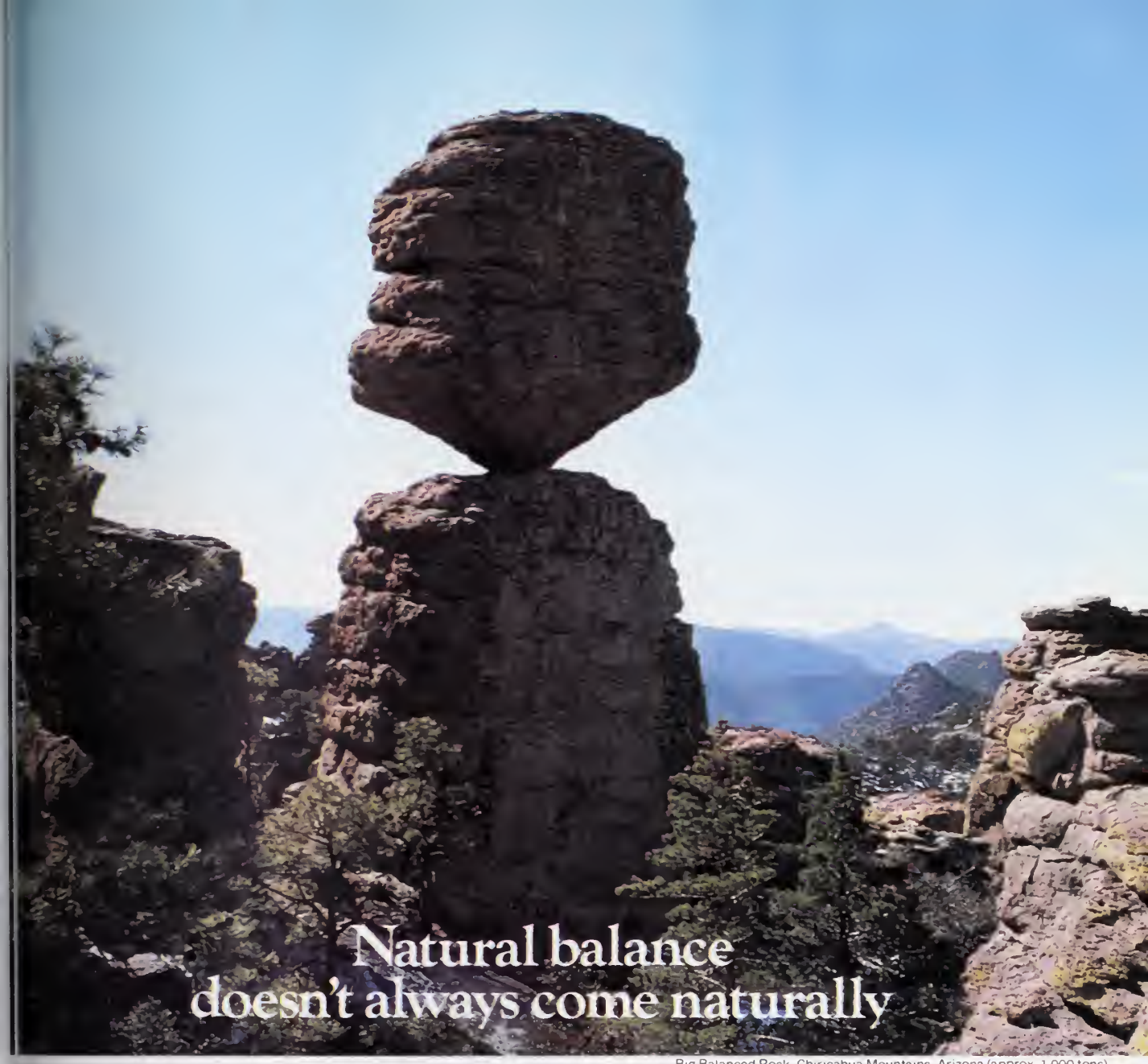
ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and aupper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.

TESTAND-B INJECTABLE: VIALS OF 10cc.

Testand-B tablets

A hormonal, nutritional supplement

Geriatric Pharmaceutical Corp.
Floral Park, New York 11001
Pioneers in Geriatric Research



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

ound useful in the management of vertigo* associated with
ases affecting the vestibular system.
Can relieve nausea and vomiting often associated with vertigo.*
Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
Also available as Antivert (meclizine HCl) 12.5 mg. scored
ets, for dosage convenience and flexibility.
Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for
nsea, vomiting and dizziness associated with motion sickness.

F SUMMARY OF PRESCRIBING INFORMATION

NDICATIONS. Based on a review of this drug by the National Academy of iences—National Research Council and/or other information, FDA has classified e indications as follows:
Effective: Management of nausea and vomiting and dizziness associated with otion sickness.
Possibly Effective: Management of vertigo associated with diseases affecting the stibular system.
Final classification of the less than effective indications requires further vestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patier package insert has been around fc a long time. Many physicians alrea use written instruction sheets to provide patients with information about the drugs they are taking. A some physicians give verbal instru tions; but in too many instances these are what I call eye-glazing e ercises. I have seen patients sit wi glazed eyes listening to a rapid-fir lecture by a hurried physician whc has 20 people out in his waiting room. These patients aren't given sufficient understanding and ther fore do not follow instructions. So think the idea of an official packag insert for patients is a good one. Perhaps we should really think of this kind of information simply as extension of drug labeling.

The benefits of patient involvemen

Many physicians may not rea ize how frequently a patient obtai his drug information from Aunt Tillie or the next door neighbor. A this information is almost alway bad or irrelevant to the case at ha Furthermore, the incentive to go along with a prescribed program i slim if the only reading matter the patient receives, along with his pr scription, is a bill.

As an educator I am impress by the principle that the best way get someone to do something is tc involve him in the process. So the

I think there are advantages well as some real disadvantages i a patient package insert. When yc begin to use semi-medical or mec cal terms to describe complicatio or possible sequelae of disease or treatment, you may frighten the p tient—particularly since the more highly sophisticated patient is not the one who is going to read the ir sert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packa insert will probably give the patie better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligati to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should bc warned of the possibility of seriou side reactions—to know what the real dangers are. But it doesn't dc bit of good to indicate that a patie on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may pos sibly outweigh the potential good

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

makes sense

For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only)

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.

"Kid, this stuff is the bananas."

Experts agree: when it comes to good-tasting banana flavor—without the unpleasant taste of paregoric—the makers of Donnagel®-PG really know their stuff!

For diarrhea

Donnagel-PG ℞

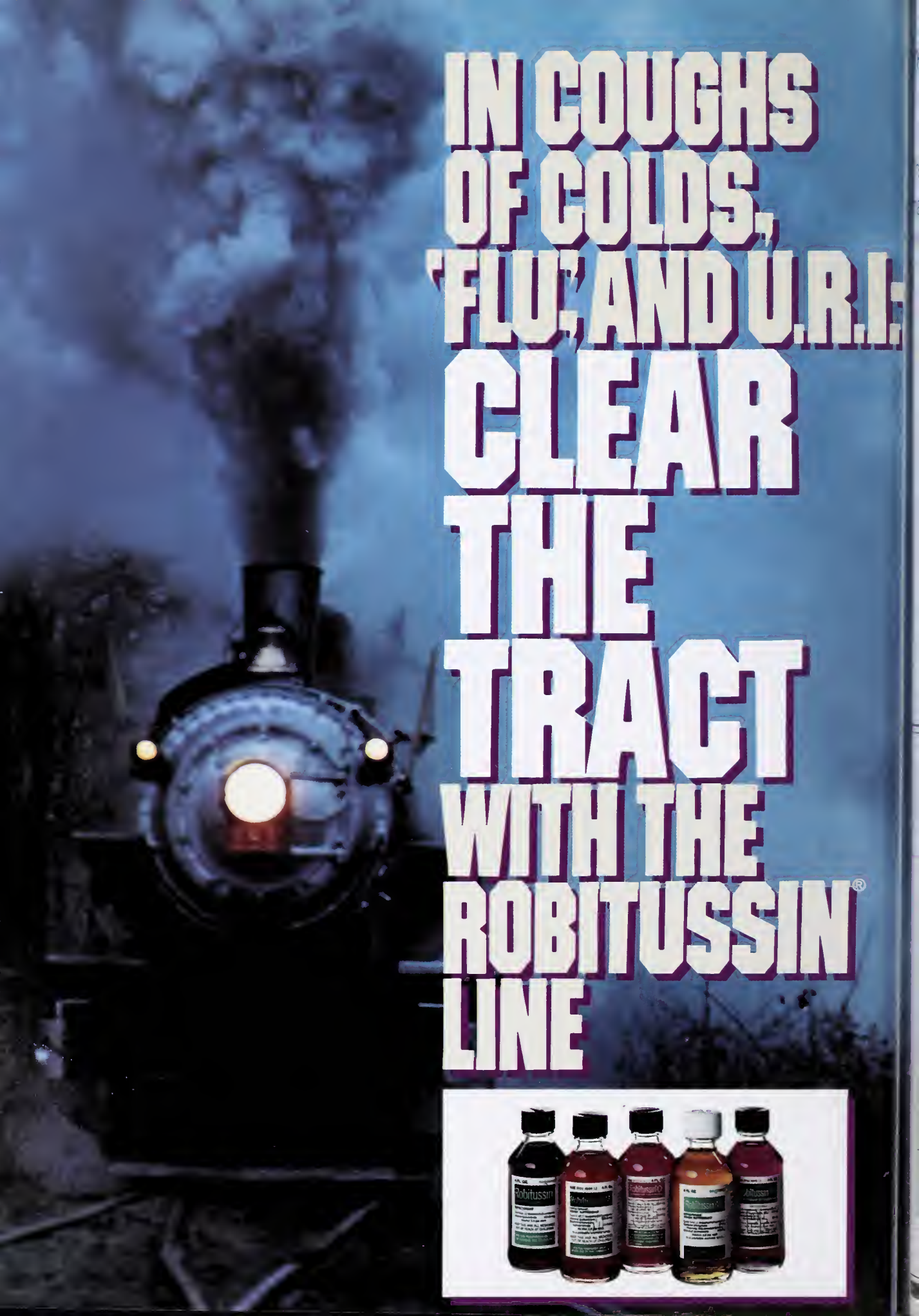
Donnagel with paregoric equivalent

Each 30 cc. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning, may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

Now with child-proof closure

A·H·ROBINS

A.H. Robins Company
Richmond, Virginia 23220


IN COUGHS OF COLDS, 'FLU, AND U.R.I.:
CLEAR THE TRACT WITH THE ROBITUSSIN® LINE
Robitussin

THE 5 **RELIABLE ROBITUSSINS** can really help clear the respiratory tract. All contain guaifenesin,* the expectorant that works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise.

*formerly named Glyceryl Guaiacolate

For productive and unproductive coughs

ROBITUSSIN®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C® Ⓥ

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Codeine Phosphate, USP ..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hr. cough control

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Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Dextromethorphan Hydrobromide, NF ..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

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Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Pseudoephedrine** Hydrochloride, NF. ..... 30 mg
Alcohol, 1.4%
**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

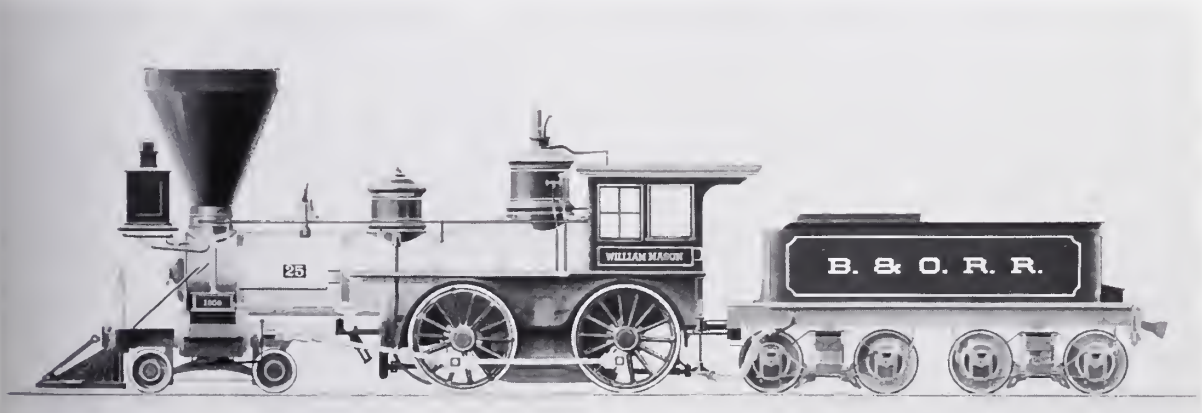
ROBITUSSIN-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 50 mg
Phenylpropanolamine Hydrochloride, NF. ..... 12.5 mg
Dextromethorphan Hydrobromide, NF. ..... 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

Dr. Brill

GOVERNOR APPOINTS THREE PHYSICIANS TO BOARD OF MEDICAL EXAMINERS . . .

Gov. Reubin O'D. Askew has announced the appointment of three members of the Florida Medical Association to the Florida Board of Medical Examiners, including the reappointment of Charles B. McIntosh, M.D., of Jacksonville.

New members of the Board are Doris N. Carson, M.D., Jacksonville, and Thomas M. Brill, M.D., Gainesville. They succeed FMA President Vernon B. Astler, M.D., Boynton Beach, and John J. Cheleden, M.D., Daytona Beach, both of whom have served on the Board for several years.

It was Governor Askew who first appointed Dr. McIntosh, a pediatrician and the first Black physician ever to sit on the Board, to a four-year term in 1971. Dr. Carson is the Board's only female member.

Dr. Brill, an allergist, is a native of Michigan. He received his M.D. degree at the University of Michigan College of Medicine in 1944, later receiving internship and residency training at the University Hospital in Ann Arbor and at Blodgett Memorial Hospital in Grand Rapids, Mich.

He is Past President of the Alachua County Medical Society, and is a member of FMA, the American Medical Association, the Florida Allergy Society, Florida Pediatric Society and the American Academy of Pediatrics.

Dr. Carson

Dr. Carson was born in Ohio and received her medical degree in the Class of 1950 at Ohio State University School of Medicine. She received her graduate medical education at Good Samaritan Hospital in Cincinnati, and at St. Lukes Hospital in Jacksonville.

Her professional memberships include the Duval County Medical Society, FMA, AMA, Florida Obstetric and Gynecologic Society and the American College of Obstetrics and Gynecology.

Dr. McIntosh is a West Palm Beach native who attended Florida A & M University, which granted him its Distinguished Alumnus Award in 1968. He received a Master of Arts degree from New York University in 1950 and his M.D. five years later at Meharry Medical College. His internship and residency training were taken at Flushing Hospital, Flushing, N. Y. and Queens Hospital Center in New York.

A former President of the Jacksonville Academy of Medicine, Dr. McIntosh has served on the Board of Directors of the Duval County Medical Society, and at the present time he is President-Elect of the Florida State Medical, Dental and Pharmaceutical Association. He also is a member of AMA, the National Medical Association and the Florida Pediatric Society.

Dr. McIntosh

UNIVERSITY OF SOUTH FLORIDA COLLEGE OF MEDICINE . . . Dean Donn Smith announced the appointment of Anthony Reading, M.D., formerly of Johns Hopkins University, as Chairman of the Department of Psychiatry.

Theron Ebel, M.D., has been named Assistant Dean for curriculum development and continuing education.

TEACHING CENTERS FROM COAST TO COAST . . . have received the first 48 graduates of the University of South Florida College of Medicine, who began their house officer training on July 1. Most of the class accepted residencies in internal medicine.

EASTERN AIRLINES . . . has promoted Julio R. Serrano, M.D., to the post of Vice President—Employee Services. An employee of Eastern since 1970, Dr. Serrano, a member of the Florida Medical Association and a Diplomate of the American College of Preventive Medicine in both aerospace and occupational medicine, will continue acting as the company's medical director.

THE AMERICAN MEDICAL ASSOCIATION IS GRATIFIED . . . that its dispute over utilization review regulation with the U.S. Department of Health, Education and Welfare has been resolved satisfactorily, according to Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees.

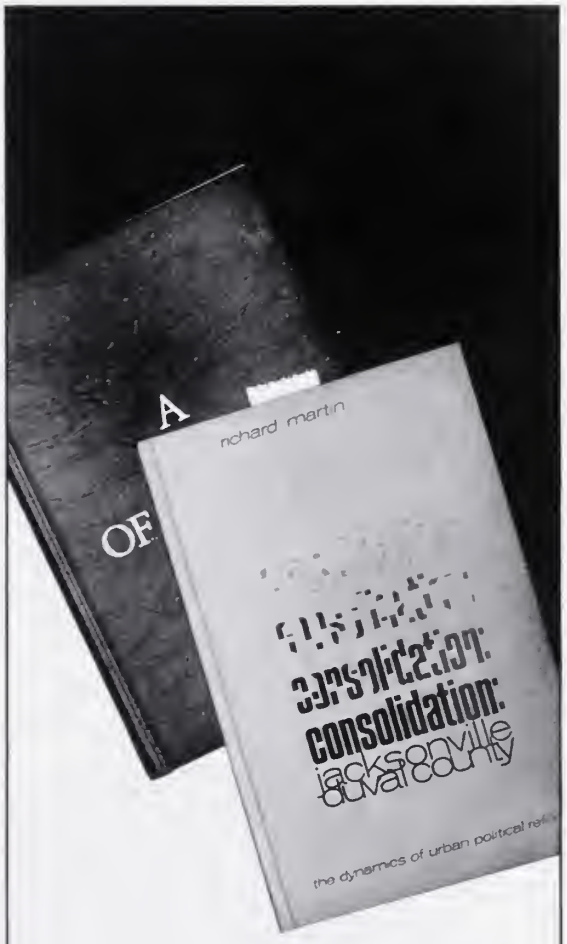
The two parties reached an agreement whereby AMA decided to drop its lawsuit. In return HEW Secretary F. David Mathews agreed to revise the regulations for review of Medicare and Medicaid hospital admissions..

The old regulations were supposed to go into effect earlier this year, but the implementation was delayed when a federal judge in Chicago granted AMA a temporary injunction. The AMA position subsequently was upheld by the Circuit Court of Appeals.

"The AMA desires to work constructively with HEW to insure that Medicare and Medicaid patients receive quality medical care in an economically and legally responsible manner," Dr. Holden stated.

A PROMINENT MEMBER OF THE BROWARD COUNTY MEDICAL ASSOCIATION . . . has called for dividing the society into districts to solve organizational problems.

Writing in the current issue of *The Broward County Medical Association Record*, Editor Lees M. Schadel, Jr., M.D., advocated creation of Hollywood, Ft. Lauderdale and Pompano districts, as well as other districts for westward expansion. "Broward County has experienced too much growth too soon," Dr. Schadel wrote. ". . . differences in geography to a great extent and philosophy to a lesser degree, have made us aware of these changes."



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When sequential contraception is preferred...

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Ortho-Novum SQ provides good cycle control

provides a low sequential dosage

effective in clinical trials, with a pregnancy rate of 0.43 per 100 woman years

generally well tolerated†

available in the unique DIALPAK* Tablet Dispenser

Ortho-Novum SQ

TRADEMARK

Each white tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

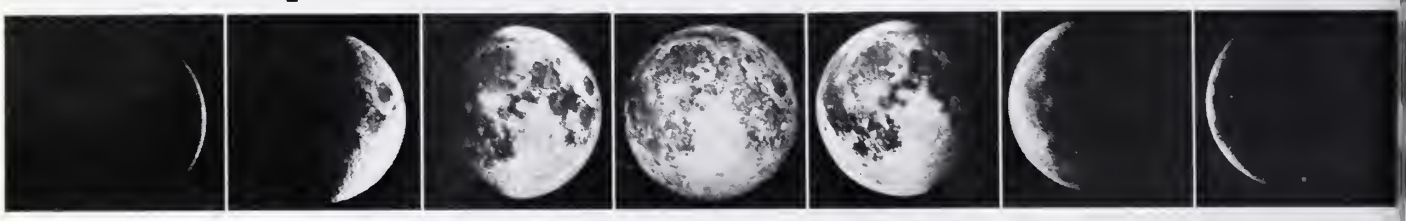
†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

*TRADEMARK

See prescribing information on following page.

OJ 622-5

In sequence...



Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SQ Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0.08 mg, and blue tablets containing both mestranol 0.08 mg and norethindrone 2.0 mg

Action: Gonadotrophin suppression

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy. Liver disease has also been reported, and the physician should be alert to its earliest manifestations.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication: Contraception.

Contraindications: 1. Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions. 2. Markedly impaired liver function. 3. Known or suspected carcinoma of the breast. 4. Known or suspected estrogen-dependent neoplasia. 5. Undiagnosed abnormal genital bleeding. 6. Known or suspected pregnancy.

Warnings: 1. The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis. Should any of these occur or be suspected, the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives. There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country.[4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about seventold, while the United States studies found relative risks of 4.4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users.

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group. This study in its interim analysis states, "A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk." The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users. The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations.

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment.

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4.1 to 9.5 times greater in users than in non-users. A comparable estimate for hemorrhagic stroke was 2.0.

None of the American studies was designed to evaluate a difference between products. However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products.

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users. It has been recommended that therapy be discontinued at least one month prior to elective surgery.

2. Discontinue oral contraceptive medication if there is: gradual or sudden partial or complete loss of vision; proptosis or diplopia; onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe, papilledema; or any evidence of retinal vascular lesions.

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy.[11,12] The safety of ORTHO-NOVUM SQ in pregnancy has not been demonstrated. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

5. Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed before prescribing oral contraceptives and periodically during their administration and should include special reference to breasts and pelvic organs, including Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. 2. Endocrine and possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ. Therefore, if such tests are abnormal in a patient taking ORTHO-NOVUM SQ, it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated. 6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 7. Any possible influence of prolonged ORTHO-NOVUM SQ therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORTHO-NOVUM SQ therapy. 9. The age of the patient constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ may mask the onset of the climacteric. 10. The pathologist should be advised of ORTHO-NOVUM SQ therapy when relevant specimens are submitted. 11. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids. 12. Cholestatic jaundice has been reported in users of oral contraceptives. If this occurs, ORTHO-NOVUM SQ should be discontinued. This condition is more likely to occur in patients who have experienced cholestatic jaundice of pregnancy. Patients with a history of cholestatic jaundice of pregnancy should be carefully observed during ORTHO-NOVUM SQ therapy.

Adverse reactions observed in patients receiving oral contraceptives: A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism, cerebral thrombosis and hemorrhage, gallbladder disease.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis, hepatic lesions with or without intra-abdominal bleeding.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma which may persist, cholestatic jaundice, migraine, rash (allergic), mental depression, change in weight (increase or decrease), breast changes (tenderness, enlargement and secretion), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, rise in blood pressure in susceptible individuals.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post-treatment, which tends to occur more frequently in women with a history of menstrual disorders; premenstrual-like syndrome; changes in libido; changes in appetite; cystitis-like syndrome; headache; intolerance to contact lenses; nervousness; dizziness; fatigue; backache; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruptions; itching; vaginitis.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function—increased sulfobromophthalein retention and other tests; coagulation tests—increase in prothrombin Factors VII, VIII, IX and X; decrease in anti-thrombin III; increase in platelet aggregability; thyroid function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease. J Coll Gen Pract 13:267-279, May 1967. **2.** Inman, W.H.W., Vessey, M.P.: Investigation of Deaths from Pulmonary, Coronary and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age. Br Med J 2:193-199, April 27, 1968. **3.** Vessey, M.P., Doll, R.: Investigation of Relation between Use of Oral Contraceptives and Thromboembolic Disease: A Further Report. Br Med J 2:651-657, June 14, 1969. **4.** Sartwell, P.E.; Masi, A.T.; Arthes, F.G.; Greene, G.R.; Smith, H.E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study. Am J Epidemiol 90:365-380, Nov. 1969. **5.** Oral Contraception and Increased Risk of Cerebral Ischemia or Thrombosis. N Engl J Med 288 (17):871-878, April 26, 1973. **6.** Oral Contraceptives and Stroke in Young Women. Associated Risk Factors. J A M A 231 (7):718-722, Feb. 17, 1975. **7.** Oral Contraceptives and Venous Thromboembolic Disease, Surgically Confirmed Gall-Bladder Disease, and Breast Tumours. Report from the Boston Collaborative Drug Surveillance Programme. Lancet: 1399-1404, June 23, 1973. **8.** Royal College of General Practitioners: Oral Contraceptives and Health. 1-100, May 1974. **9.** Vessey, M.P., Doll, R., Fairbairn, A.S.; Glober, G.: Postoperative Thromboembolism and the Use of Oral Contraceptives. Br Med J 3:123-126, July 18, 1970. **10.** Greene, G.R.; Sartwell, P.E.: Oral Contraceptive Use in Patients with Thromboembolism Following Surgery, Trauma, or Infection. Am J Public Health 62(5):680-685, May 1972. **11.** Nora, J.J.; Nora, A.H.: Birth Defects and Oral Contraceptives. Lancet: 941-942, April 28, 1973. **12.** Janerich, D.T.; Piper, J.M.; Glebatis, D.M.: Oral Contraceptives and Congenital Limb-Reduction Defects. N Engl J Med 291(14):697-700, Oct. 3, 1974.

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The new Child Service is directed by a fully-trained child psychiatrist who has had previous experience with the direction of a child unit. Ten child psychiatrists and several child psychologists are involved in the program, and the staff works as a team in diagnosis, treatment and rehabilitation under the direction of a child psychiatrist.

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Peachtree and Parkwood is a comprehensive mental health center which includes alcohol rehabilitation and drug treatment as well as psychiatric treatment for adults, adolescents and children. Complete information on services and facilities may be obtained by writing or calling the Admissions Director:

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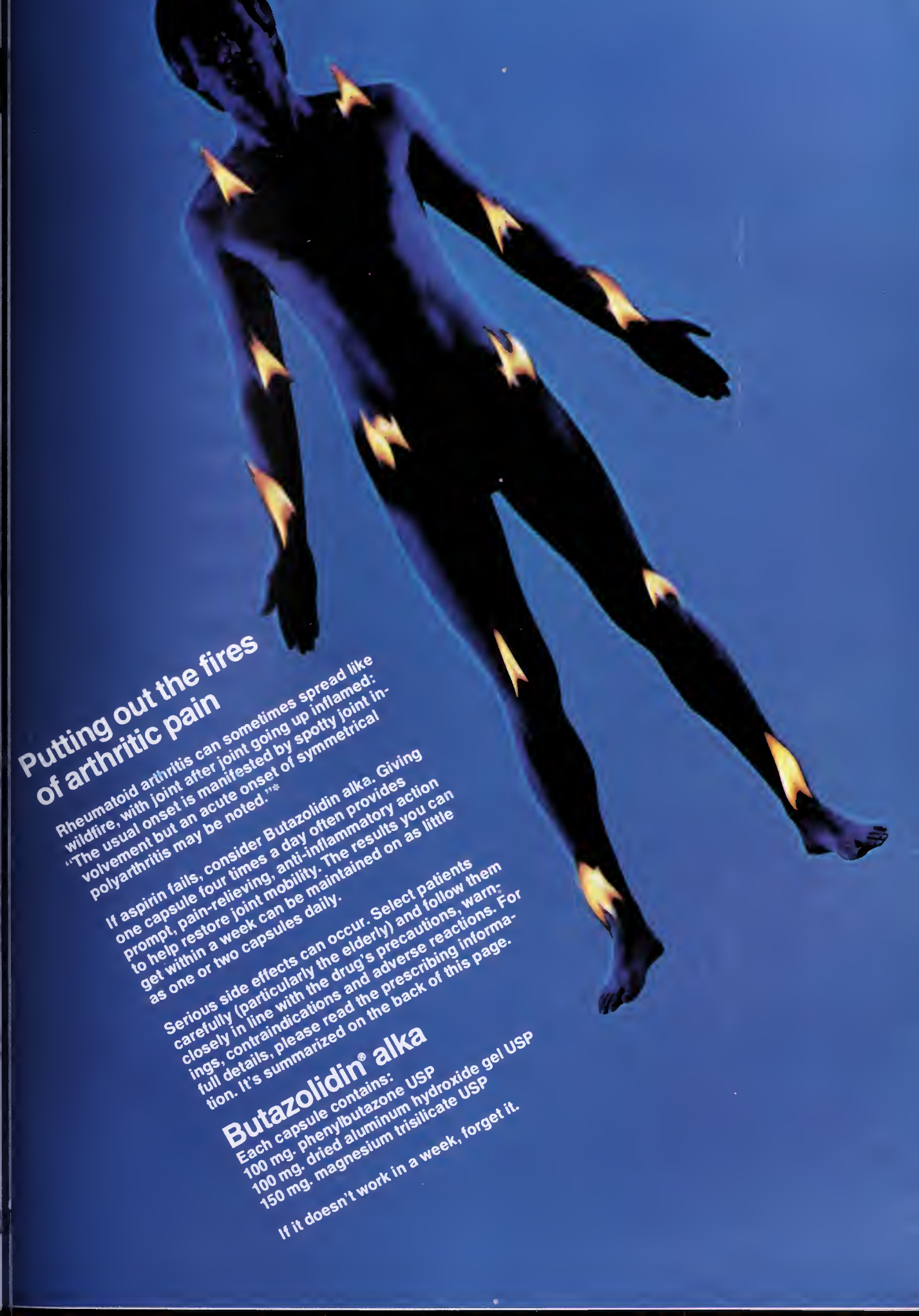

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

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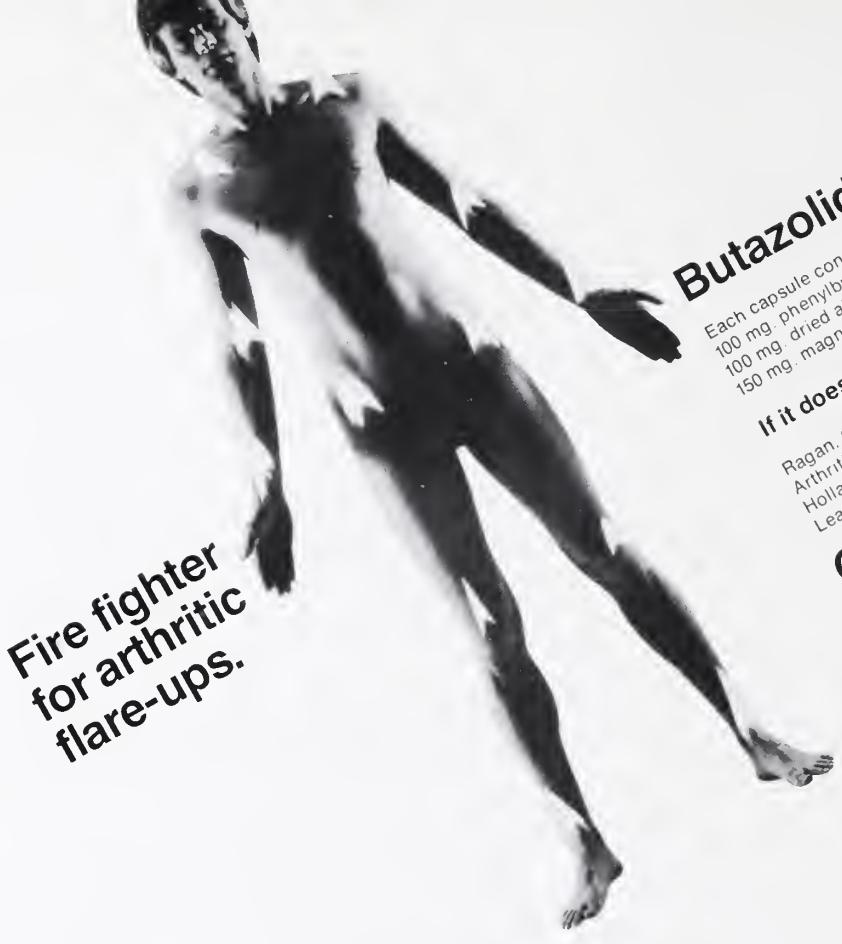

Fire fighter for arthritic flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
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If it doesn't work in a week, forget it.

Ragan, C. The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction; hypertension, thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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Of course, the prevalence of keratotic lesions is greater in locations south of the 38th parallel—the so-called "Solar Keratosis Belt"—receiving the greatest amounts of solar radiation. However, solar keratosis can occur among any light-skinned population, usually in persons over 40, wherever people are subject to extended exposure to the sun.

Solar keratoses are generally not difficult to identify.

These skin lesions are usually multiple, flat or slightly elevated, brownish or red in color, papular, dry, rough, adherent and sharply defined. They are found on areas of the skin having extensive exposure to sunlight. Clinical characteristics of the lesions, their predominant location on exposed surfaces, the age of the patient and his skin type are important considerations in the diagnosis.

Solar keratoses can, and should, be treated because they are potentially premalignant.

Chronic exposure to sunlight frequently leads to degenerative changes in the skin. This can often result in the development of multiple, potentially premalignant keratotic lesions. Therefore, early detection and treatment is advisable.

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Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris (hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

OCTOBER, 1975 • VOLUME 62 • NUMBER 10

Penile Prosthesis
New Implant for Management of Impotence

MICHAEL P. SMALL, M.D. AND HERNAN M. CARRION, M.D.

Abstract: Excellent results have been obtained in over 37 patients using a new penile implant which consists of a silicone shell and a silicone sponge interior. The prostheses are inserted into the corpora cavornosa and give the feeling and appearance of the normal erect penis. The prostheses are available in multiple sizes and the proper size is selected for each patient at the time of surgery. Complications have been minimal.

Inspired by plastic surgeons in their development of more ideal implantable breast prostheses, the Small-Carrion penile prosthesis was designed and developed for those patients whom existing penile prostheses were believed inadequate. A more flexible and normal feeling material, which would not only add length to the phallus but width and firmness as well, was assembled in the form of a medical grade silicone exterior with silicone sponge interior.

The idea of a paired penile prosthesis was maintained at a level of most basic simplicity—deleting any mechanical or hydraulic innovations while incorporating certain physiologic advantages which helped eliminate problems encountered with earlier prostheses.[1-8] These problems which included extrusion, lymphatic edema, penile irritation, pain and slippage have been found to be virtually eliminated when this prosthesis is implanted properly. The recommended surgical technique has obviated these complications in almost all except the most unusual cases. Perhaps for this reason, interest in the implant and results have been gratifying.

As available,* the implant in paired form appears to have the ideal qualities desirable in a penile prosthesis—giving adequate width, length and consistency most similar to the erect penis. It is available in four lengths—12 cm, 13.3 cm, 14.5 cm, and 15.8 cm—and two diameters—0.9 cm, and 1.1 cm (Fig. 1). The narrower diameter is usually needed in patients in whom difficulty is encountered in dilating the corpora cavernosa—as in those who have had priapism, inflammatory disease of the corpora, or extensive penile trauma. The proximal portion of the prosthesis is curved to fit the crus of the penis. Rigidity in this area allows for adequate support at the crus and ischial tuberosities. The prosthesis lends itself well to sterilization in the hospital autoclave.

Surgical Approach

A perineal surgical approach is advised to prevent unnecessary scarring of the phallus. The

From the Department of Urology, University of Miami School of Medicine, Miami. Dr. Small is Clinical Professor of Urology.

*Heyer-Schulte Corp., Goleta, Calif. 93017

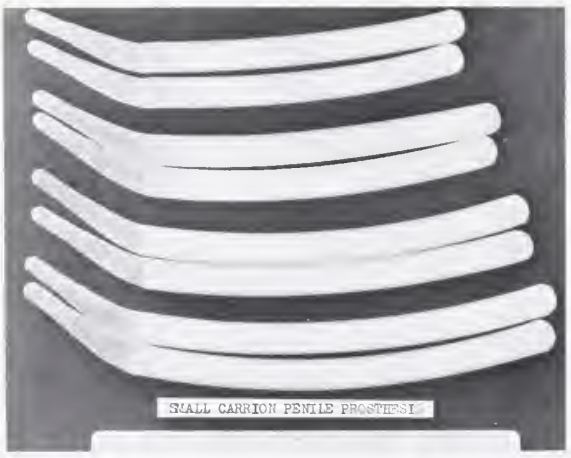

Figure 1

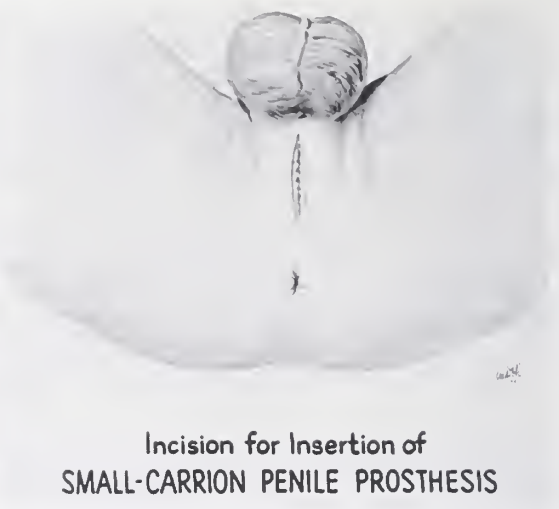

Figure 2

patient is placed in the dorsal lithotomy position and a catheter is placed in the urethra for identification purposes. A vertical midline incision is made from the base of the scrotum toward the anus and the incision is carried down to the bulbocavernosus muscle (Fig. 2). The bulbocavernosus and urethra are retracted to one side and the ischial cavernosus muscle and the crus of the penis are identified (Fig. 3). If difficulty is encountered in finding these structures, firm compression of the penis will give an impulse in the area of the crus. Once the crus has been identified it is opened for a length of approximately 2 cm. Hegar dilators are then used to dilate the crus of the penis proximally to the ischial tuberosity and distally for the complete extent of the corpora cavernosa (Figs. 4, 5). It is imperative that dilatation be carried completely under the glans penis so that the prosthesis will fit firmly in this area and not allow the glans to flex over the implant. Dilation is usually started with a number 5 Hegar dilator and if there is no scarring in the corpora, it is quite easy to dilate to a number 10 or 11. When dilating proximally care must be taken not to perforate the crus.

All four lengths and both diameters of the prostheses should be available at the time of surgery so that the proper size may be selected. We have found that the 14.5 (long) or 15.8 (extra long) size and the wide diameter will usually be required. The prosthesis should fit firmly against the wall of the corpora cavernosa. The distal end

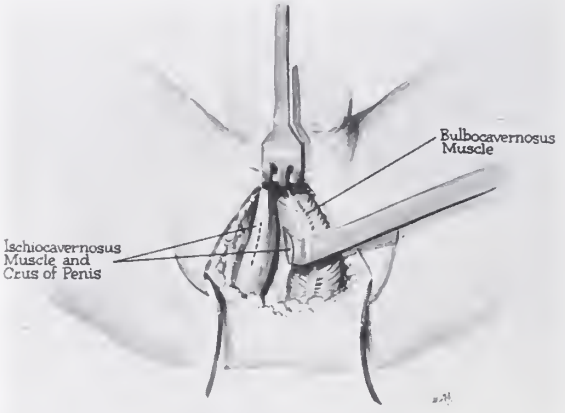

Figure 3

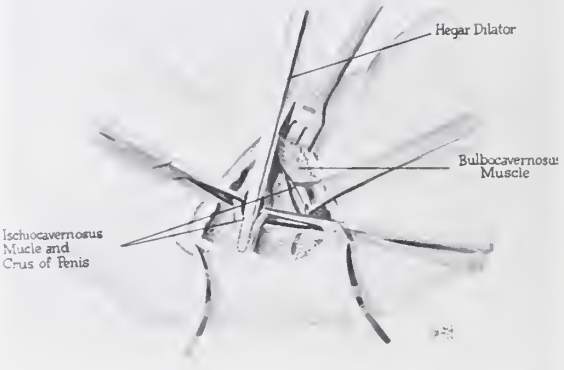

Figure 4

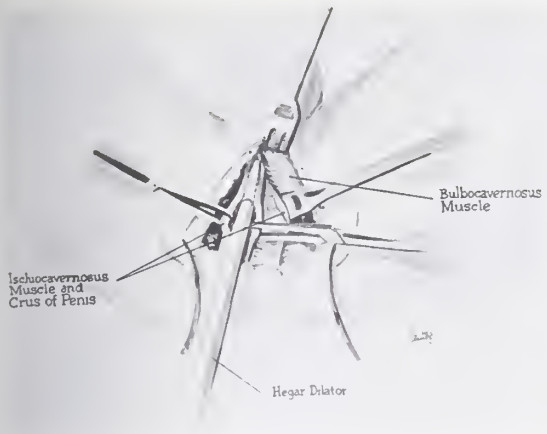

Figure 5

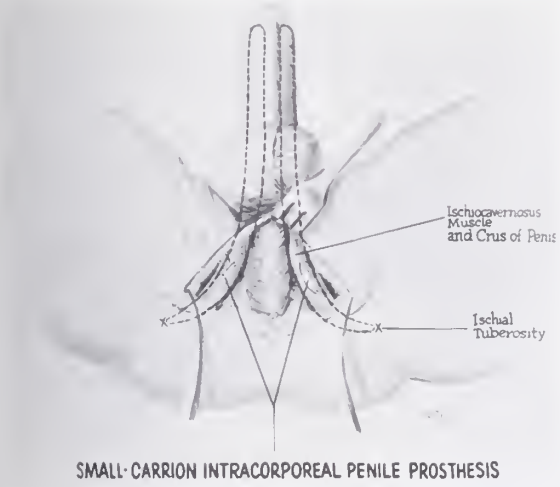

Figure 6

should extend to the tip so the glans penis fits firmly and correctly over the prosthesis. After one prosthesis has been inserted, the same procedure is carried out on the contralateral side (Fig. 6). Incisions in each corpora are closed with running 3-0 chromic catgut sutures. The remainder of the wound is closed in a routine manner. Drains are not used and the urethral catheter is removed immediately after surgery. During the initial portion of the operative procedure the implants are soaked in an antibiotic solution (Polymyxin-neomycin) and after implantation the wound is irrigated with the same solution. All patients are also started on a broad spectrum antibiotic prior to surgery and continued postoperatively for several days. The patient may be discharged from the hospital in four or five days and intercourse is allowed in two or three weeks.

In patients who are impotent after pelvic fracture or who have had proximal urethroplasty, incisions may be made laterally directly over the crura or dorsally in the midline at the penoscrotal junction in order to avoid a previously scarred area. The remainder of the operation is identical to that which has been described.

Conditions and Complications

In the period February 1973 to January 1975 the prosthesis was implanted in 41 patients ranging in age from 19 to 72 years (Table 1). Four patients were impotent after prostatectomy, two after priaprism, two had psychogenic impotence, 11 had impotence because of generalized arteriosclerosis, three were impotent secondary to pelvic fractures, 15 had spinal cord injuries, three were impotent secondary to diabetes, and one was born with extrophy and epispadias. Several patients had Pearman prostheses which proved unsatisfac-

Table 1.—Classification and Results of Patients Having Prosthesis.

DIAGNOSIS	NUMBER OF PATIENTS	RESULTS
Postprostatectomy	4	Excellent
Postpriapism	2	Excellent
Psychogenic	2	Excellent
Pelvic fracture	3	Excellent — 2 Partial failure (lost 1 prosthesis secondary to infection) — 1
Arteriosclerosis	11	Excellent
Spinal cord injury	15	Excellent — 13 Partial failure (one prosthesis lost secondary to infection) — 1 failure (incorrect placement of prosthesis) — 1
Diabetes mellitus	3	Excellent
Epispadias and extrophy	1	Good (small phallus)
Total	41	

tory because of irritation at the glans penis and, in retrospect, were also not satisfactory to the female partner.

Complications have been minimal (Table 2). Two patients had urinary retention which was temporary and required Foley catheter drainage for 24 hours. Two patients extruded prostheses transurethrally. One of these patients had been on Foley catheter drainage for a long period and had also undergone transurethral prostatectomy and spincterotomy. The other patient required surgery at the penoscrotal junction ventrally and subsequently a wound infection developed in one corpus cavernosum. After extrusion of the prosthesis, the wounds and urethras healed satisfactorily and both patients are having adequate intercourse, although probably not optimal, with the one remaining intracorporal penile prosthesis. One patient had incorrect placement of the prostheses requiring subsequent removal. This patient had extensive scar tissue in the perineum secondary to periurethral abscess formation and proximal urethroplasty. Three patients had superficial wound infections which healed without sequelae.

Discussion

The adequate management of impotence has always been an enigma to urologists as well as other physicians dealing with this disease entity. After the patient has undergone thorough urologic and endocrinologic evaluation, sex counseling, possible psychiatric therapy and even an empiric course of androgen therapy without response, implantation of a penile prosthesis should be considered. Bilateral intracorporeal placement is a physiologically sound approach because it more closely simulates normal erection. In the described location, the prosthesis gives added length, excellent support because of the firmness of the corpora and perhaps even more importantly added width to the penis. This prosthesis accomplishes all of these. By using a medical grade silicone shell with silicone sponge interior, the shape and consistency of a normal erection is obtained. The prosthesis is firm; however, there is enough flexibility to keep the phallus inconspicuous under jockey or bikini-type shorts either in the normal position or against the abdominal wall after healing is complete.

To obviate scar formation on the penile shaft, a perineal approach is advised; however, in pa-

Figure 7

Fig. 8. — Postoperative results in Figs. 7 and 8.

TABLE 2.

Complications	Number of Patients
1. Urinary retention(temporary)	2
2. Severe wound infection with extrusion of prosthesis	2
3. Incorrect placement of prosthesis	1
4. Superficial wound infection (without sequelae)	3
5. Total serious complications	3
Total patients	41

tients who have marked periurethral induration or scar formation, lateral incisions or a more distally placed midline incision may be utilized to avoid dissection through a scarred perineum. Patients who have a perineal approach may resume sexual activities sooner than those with a penile incision.

Insertion of the prosthesis in impotent spinal cord-injured patients with neurogenic bladders has an additional advantage. The added length and girth provided allows those with a small phallus who have difficulty keeping an external collection device in place to do so quite easily.

Caution must be exercised in patients with neurogenic bladders who have borderline decompensation. Elongating and possibly compressing the shaft of the urethra may increase resistance enough to cause further decompensation. This may necessitate external sphincterotomy with the prosthesis in place. These patients should be fully evaluated prior to inserting the prosthesis and performing any transurethral surgery. If a prosthesis has already been implanted and it later becomes necessary to do transurethral surgery, approach through a perineal urethrostomy should be considered. These findings have led to an additional advantage with the prosthesis. In patients who are impotent and partially incontinent following prostatectomy, elongating and compressing the urethra increases resistance to voiding and has given a select group of incontinent patients urinary control.

Conclusion

Excellent results have been obtained in 37 patients and good result in one using this prosthesis. Of the three patients with serious initial complications, adequate functional results were attained in two. The distinct advantages and potential complications using the prosthesis as well as the recommended surgical technique have been discussed. We believe this prosthesis offers a badly needed and medically sound alternative to the existing conventional treatments for impotence. Typical postoperative results are presented in two patients (Figs. 7, 8).

Addendum: Since January 1975, an additional 19 patients have had insertion of the Small-Carrion penile prosthesis. No further complications have been encountered and this group has mainly had Diabetes Mellitus, pelvic trauma and arteriosclerotic vascular disease as the etiology of their impotence.

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Reversal of "Stone Heart"

Report of Case

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Abstract: "Stone Heart" was coined by Cooley, et al., for a characteristic tetanic contracture of the heart which has been heretofore uniformly fatal. This condition develops during the course of open heart surgery when ischemic arrest is used. It is seldom seen when the ischemic arrest time is less than 40 minutes. The left ventricle becomes unusually spastic and remains severely contracted, while the right ventricle may beat normally. The usual resuscitative measures are fruitless and death occurs on the operating table.

Successful reversal of such a case developed during the course of coronary bypass is presented. Ischemic arrest was thought to be the cause, and nitroglycerin was given credit for the reversal.

Report of Case

A 41-year-old Caucasian male was admitted to the hospital on July 17, 1972, for elective coronary bypass. Selective coronary arteriorgram and left ventriculogram done a few days prior to admission revealed a high degree of occlusive disease in the left anterior descending and circumflex arteries. There was minimal occlusive disease in the right coronary artery. He had disabling angina with crescendo pattern for six months. The physical examination was unremarkable. On July 18, 1972 an aorto-coronary bypass to the circumflex and left anterior descending coronary arteries using the saphenous vein was performed. The operation was conducted under normothermia and ischemic arrest. The total pump time was 60 minutes and ischemic time 55 minutes. After completion of the procedure the left ventricle was found to be markedly contracted and the left ventricular cavity obliterated. Electrical defibrillation was attempted and the right ventricle began functioning normally but the left ventricle remained severely contracted. It had typical features of "stone heart." Since the usual resuscitative measures had failed in our previous experiences, it was decided not to use any drugs except nitroglycerin and a steroid. Two tablets of nitroglycerin (0.4 mg.) were given sublingually and 500 mg. Solu-Medrol® intravenously. The heart was held in the upright position and extracorporeal circulation was continued for approximately ten minutes.

The left ventricle started to loosen up slowly and within five minutes fine fibrillation started. Within five to ten minutes the left ventricle was relaxed with fairly good fibrillation. The heart was then defibrillated electrically and normal sinus rhythm with grossly abnormal EKG was obtained. At the beginning the EKG showed severe STT changes and markedly widened QRS complexes; however, the EKG slowly returned to normal within 20 minutes. The patient required a cardiac stimulant (epinephrine drip) for the first 36 postoperative hours and was subsequently digitalized for early congestive failure. He was discharged on the tenth postoperative day. The patient is now free of angina and other cardiac symptoms and has returned to his full-time job without receiving any cardiac medication.

Discussion

Ischemic arrest of the heart induced by cross-clamping of the aorta appears to be the major factor, if not the sole factor, in "stone heart." The exact mechanism is not clearly understood.[2] It is, however, well known that continuous and repeated contraction of a striated muscle may result in oxygen debt, ATP depletion, and tetanic contracture (rigor). After the aorta is cross-clamped, the heart continues to beat for several minutes and a severe oxygen debt and ATP depletion results without adequate coronory profusion. Ventricular fibrillation adds further to the oxygen debt and may cause tetanic contracture of the myocardium. It is intriguing that restoration of coronary circulation after removal of the aortic clamp does not reverse the condition. We believe that severe spasm of the coronary system (arterioles, capillaries, sinosoides, venules) as a result of an accumulation of end products of anaerobic metabolism of myocardial cells may prevent the richly oxy-

genated blood from reaching the cellular level of myocardium. Nitroglycerin, a potent vasodilator, may break this spasm and allow the ATP-rich oxygenated blood to reach the myocardial cells and reverse the tetanic contracture. This assumption is further strengthened by the fact that "stone heart" is not seen in cardiac centers where nitroglycerin is used routinely.[3]

Cardiac massage in "stone heart" is not only without value but may damage the myocardium which is already maximally contracted. Whether or not steroids are of any value remains to be determined. Holding the heart in an upright position enhances the coronary venous return but, again, its real value is not clear. The right ventricle may continue to beat normally in the presence of "stone heart" which indicates that it is not a systemic disorder but a local one (oxygen debt of the left ventricular myocardium). The high incidence of "stone heart" in patients with left ventricular hypertrophy reported by Cooley et al[1] emphasizes the importance of anaerobic metabolism of the left ventricle in relation to "stone heart."

The judicious use of nitroglycerin in patients undergoing open heart surgery with ischemic arrest may prevent "stone heart." Nitroglycerin, however, in larger doses tends to cause severe vasodilatation with pooling of blood in the splanchnic system and systemic hypotension. Its routine use, therefore, should be reserved for patients with left ventricular hypertrophy and those requiring long pump time.

In our opinion the only assured way of preventing "stone heart" is to limit the time of ischemic arrest to 40 minutes or less.

Summary

Successful reversal of a case of "stone heart" which developed during the course of coronary bypass is presented. Ischemic arrest was thought to be the cause, and nitroglycerin was given credit for the reversal.

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Proximal Subclavian Artery Stenosis

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Abstract: Significant proximal subclavian artery stenosis may be clinically suspected when there exists complaints of upper extremity intermittent claudication with or without symptoms compatible with vertebral basilar artery insufficiency. Associated findings of decreased radial pulse, blood pressure difference of 20 mm or more between the two arms and localized supraclavicular bruits add further suspicion. Arteriography confirms the diagnosis. In the majority of clinical examples, the lesion is located on the left side, perhaps secondary to wider angle of take off of the subclavian artery from the aorta with increased turbulence of flow. The patients are generally middle-aged men, and the usual basis for the significant obstruction is an atheromatous plaque.

Two additional examples are presented of clinical proximal subclavian artery stenosis. Both patients were women. Presentation was acute in one. Syphilis may possibly be incriminated in production of the condition in the second patient.

Intermittent claudication with or without trophic changes involving the upper extremity suggests the presence of compromise of blood supply via the subcavian artery. Findings of a fixed significant difference of 20 mm or more blood pressure between the arms and a loud supraclavicular bruit, ipsilateral in location, add further credence to the suspected diagnosis. Central nervous system symptoms, brief in duration and compatible with vertebral basilar artery insufficiency, should be explained as fully as possible for complaints of vertigo, dizziness, ataxia or even brief periods of extremity weakness and visual disturbance may be additional clues suggesting the presence of obstruction.

Two examples of this type of vessel obstruction are described, which illustrate different modes of presentation of the resultant symptom complex. The emphasis on complete physical diagnosis is stressed especially blood pressure measurements in both upper extremities and careful auscultation over all readily available large blood vessels.

Report of Cases

Case 1.—A 41-year-old female was seen in the office for evaluation of pain in the left upper extremity confined to the shoulder, upper arm and associated with cyanosis of three fingers. Discomfort had been present for approximately 12 hours. History revealed that for at least a year and a half she had noted definite pain in the left upper arm and slight weakness of the entire extremity after any exercise such as morning calisthenics, playing tennis or skiing.

The night before onset of complaints she flew from New York City to Miami. During the flight, which lasted over two hours, she slept with her head flexed to the left and against the shoulder of her husband. This position did not vary. Several hours after she had retired she was awakened with the pain. Total time elapsed since leaving New York City was approximately six hours.

The family history was positive for diabetes mellitus, hypertension and coronary heart disease. There was no knowledge of familial disturbance in the handling of lipids. The patient had labile hypertension requiring no medication.

Pertinent physical findings were confined to the cardiovascular system. Blood pressure in the right arm was 160/100 mm Hg. Radial pulses were equal in rate but the volume was diminished on the left. Indirect measurement of the systolic blood pressure by sphygmomanometer on the left was 140 mm Hg. A loud bruit was heard over the left supraclavicular fossa. Cyanosis of the left distal phalanges of fingers two, three and four was present. A difference in temperature between the digits of both hands could not be appreciated. Fundal vessels were minimally narrowed. Cardiac examination was not remarkable. All the pulses in the lower extremities were palpable and no bruits were noted. Arrangements were made for transfer to a local hospital for further study and treatment.

Angiography including retrograde aortic arch study and selective brachiosubclavian arteriography was carried out next day (Figs. 1-2). A large, filling defect located in the proximal portion of the left subclavian artery, compatible with thrombus, was evident. A subclavian artery steal with retrograde vertebral flow filling was demonstrated on these preoperative studies.

The patient was taken to the operating room where a transthoracic proximal subclavian thromboendarterectomy was carried out. Postoperative course was uncomplicated until the second day when disappearance of the left radial pulse was noted. Repeat angiographic studies revealed occlusion of the proximal subclavian artery (Fig. 3). A carotid-subclavian artery anastamosis employing a graft restored continuity of flow and the remainder of her hospital stay was uncomplicated. She was discharged on the 13th day.

Analysis of this case reveals the presence of symptomatic proximal subclavian artery obstruction for nearly two years manifest by intermittent claudication. It is hypothesized that an acute insult to the atheromatous plaque in the vessel with subsequent superimposed thrombus formation resulted from the unusual position in which the left arm rested during the recent airplane trip. The vessel was possibly kinked with disruption of the plaque, bleeding and further narrowing of the arterial lumen. Microemboli to the digital arteries may have accounted for the trophic changes involving the fingers.

Fig. 1.—Preoperative aortic arch study. Occlusion of proximal left subclavian artery. The distal portion of the vessel is visualized as filling from ipsilateral retrograde vertebral artery flow. CA, carotid artery. VA, vertebral artery. IA, innominate artery. DSA, distal subclavian artery.

Fig. 2.—Selective brachiosubclavian arteriography. A large thrombus originating in the proximal portion of the left subclavian artery is demonstrated. VA, vertebral artery. SA, subclavian artery.

Fig. 3.—Postoperative aortic arch study. Reveals reocclusion of the proximal left subclavian artery. Subclavian artery steal is noted due to retrograde flow in the ipsilateral vertebral artery with subsequent filling of the distal subclavian artery. CA, carotid artery. VA, vertebral artery. SA, subclavian artery. IA, innominate artery. DSA, distal subclavian artery.

Case 2.—A 62-year-old Caucasian female was evaluated in the office for an episode of chest pain consistent with angina pectoris. During the examination, a 35 mm Hg difference in upper extremely blood pressure was noted with the left brachial artery pressure being lower than that of the right. No bruits were recorded over any of the large peripheral arteries.

The patient's daughter, a registered nurse, had first noted the blood pressure discrepancies three years previously, and two years later the patient was seen in neurologic consultation for complaints of dizziness, vertigo, tinnitus and ataxia. No further study was suggested.

Past history revealed a knowledge of a positive serology for approximately 40 years. The patient had been treated with arsenicals and several courses of penicillin but continued to have a reactive serology. Review of systems and subsequent complete physical examination revealed no evidence to suggest the presence of luetic aortic insufficiency or central nervous system syphilis.

Further evaluation of the vascular disease by means of coronary angiography and aortic arch study was suggested, and the patient was referred to The Cleveland Clinic.

Left heart catheterization and angiographic study were performed. A localized 75% stenosis was found of the anterior descending branch of the left coronary artery. In addition the studies demonstrated slight dilatation of the ascending aorta with heavy calcification of the anterior wall as well as a severe stenosis of the proximal left subclavian artery. There was no evidence of an aortic valve lesion (Figs. 4-6).

Clinic physicians believed that the lesion in the subclavian artery was most likely on the basis of atherosclerosis, not luetic arteritis, and that her symptoms did not warrant subclavian artery endarterectomy. In addition, it was surmised that surgery for relief of angina pectoris might require a free internal mammary graft and in view of the suggestive findings of syphilitic aortitis, there could well develop technical problems with the proximal anastamosis, for if there was an active inflammatory process, this might lead to early occlusion of the graft.

Figs. 4 & 5.—Posteroanterior and lateral views of chest. Slight dilatation of the ascending aorta associated with heavy calcification in this area of the vessel is evident. A, aorta.

Fig. 6.—Selective opacification of the left subclavian artery in the left anterior oblique projection. A large irregular constricting lesion is present in the proximal portion of the subclavian artery. SA, subclavian artery.

Comment

Precise information regarding the true incidence of subclavian artery stenosis is incomplete for in addition to the clinically suspected and well-documented examples of symptomatic lesions another significant but not precisely recorded number of lesions are noted during angiographic studies initiated to elucidate other vascular syndromes.[1,2]

Subclavian artery stenosis may be suspected by information gathered by accurate history taking, complete physical examination including auscultation over the root of the neck and supraclavicular fossae and recording blood pressures in both upper extremities.[3] A discrepancy of blood pressure between the two arms may be the only physical finding suggestive of subclavian artery narrowing. However, significant stenosis of one or more subclavian arteries may produce quite dramatic clinical complaints and physical findings.

The presence of significant proximal occlusion of a subclavian artery results in collateral flow to the distal portion of the vessel.[4] The largest supplementary route is the vertebral artery which has communications with the external carotid, contralateral vertebral and basilar arteries. When blood pressure in the distal portion of the involved artery falls below that in the basilar artery, reversed flow in the ipsilateral vertebral artery may take place. This change in direction results in vertebral and basilar artery insufficiency, symptoms referrable to a direct consequence of diversion of blood away from cerebral tissue to the distal subclavian artery. Contorni in 1960 first demonstrated angiographically this reversed flow in the vertebral artery in a patient with proximal subclavian artery stenosis.[5] He injected contrast medium into the contralateral brachial artery of a patient with an absent left radial pulse. Flow proceeded up the right vertebral artery, down the left vertebral artery and then filled the portion of the subclavian artery distal to the obstruction. One year later, in 1961, Reivich made the correlation between proximal subclavian artery stenosis and cerebral vascular symptoms suggesting vertebral-basilar artery insufficiency.[6] An editorial in the same issue of the publication suggested the term "subclavian steal" to characterize the retrograde flow on the ipsilateral side of the proximal subclavian artery stenosis.

Thus patients with significant proximal stenotic lesion of a subclavian artery may present clinically with symptoms suggesting vertebral-basilar artery insufficiency. Angiographic studies have helped correlate these complaints as being the secondary effects of proximal obstruction of a subclavian artery with subsequent change in pressure relationships. The fall in pressure in the distal portion of the vessel brings about retrograde flow in the ipsilateral vertebral artery with resultant deprivation of cerebral tissue and ischemic symptoms clinically.[7]

Intermittent claudication of an upper extremity may be the initial complaint suggesting the presence of significant proximal subclavian artery stenosis.[8] The painful extremity may be only appreciated after exercise as a secondary, brief intermittent effect of meeting the demands for increased flow to the arm associated with a repetitive activity. Further compromise of the blood flow to the extremity, however, as a result of trauma with perhaps formation of a secondary thrombus on an already localized atherosclerotic plaque may lead to more dramatic complaints as noted in case one; namely, secondary trophic changes of digits with cyanosis and weakness felt to be related to formation of microemboli from the enlarging obstructing lesion.

A number of conditions have been implicated in causing significant obstruction of a subclavian artery. Clinically, an atherosclerotic basis must be considered the most common intrinsic cause, although other etiologies are recognized.[9] Congenital anomalies such as arteriovenous malformations, vascular rings adjacent to esophagus and trachea causing compression of a vessel, and aortic arch duplications may produce significant extrinsic obstruction to subclavian artery flow. Traumatic injury to a vessel secondary to knife or bullet wounds are well-documented as causing subsequent ischemic symptoms. Finally, any of the so-called causes of symptomatic thoracic-outlet compression syndromes may cause ischemic symptoms referrable to one or more upper limbs. However, symptoms will not be constant and diagnostic maneuvers such as the costoclavicular, Adson and hyperabduction which produce compression of vascular and neurogenic structures against the first rib generally will aggravate the symptoms referrable to the limb, ie., claudication or decrease the volume of the radial pulse.[10] Once the abnormal position of structures at the neck and shoulder is reversed by cessation of the maneuver, complaints referrable to the limb will be relieved. The absence of fixed symptoms and presence of same only with movements of neck and shoulder girdle, therefore, suggest musculoskeletal causes for extremity symptoms rather than persistent intraluminal obstruction of the proximal portion of a subclavian artery.

Poorly understood inflammatory conditions such as giant cell arteritis of the so-called Takayasu's type may affect the aortic arch and proximal portion of the subclavian artery producing obstructive symptoms. Angiographically, retrograde flow in the vertebral artery on the side of the obstruction, the "subclavian steal" has been demonstrated in examples of this entity.[11] The "steal" has also been recorded in studying patients who have had a previous Blalock-Taussig anastamosis for congenital cardiac anomalies associated with pulmonary stenosis or atresia. This historic surgery consisted of the anastomosis of subclavian artery to pulmonary artery in an attempt to overcome the deficient vascular flow

associated with the congenital anomaly. In one series studied, seven of 12 patients had symptoms suggestive of basilar artery insufficiency.[12]

No example of arteritis secondary to an infectious etiology could be found in a careful review of the recent medical literature. Case 2 describes a patient with positive serology and changes in the thoracic aorta compatible with syphilis. Angiographically, significant obstruction of the proximal left subclavian artery was clearly demonstrated, but these extensive changes could not be pathologically correlated as secondary to the endarteritis of syphilis with engrafted atherosclerotic changes of the intima producing significant obstruction of the vessel.

A review of the medical literature up to approximately 25 years ago revealed syphilis to be the prime etiology of obstructing lesions of the vessels arising from the aortic arch. The significant occlusion of one or more subclavian arteries with resultant diminished pulse volume and discrepancy between upper extremity blood pressures was well-documented and noted to be present with and without associated syphilitic aortic aneruysm.[13]

In an extensive review of aortic arch syndromes, Ross and McKusick described associated clinical findings in some of the early reported examples of difference in upper extremity blood pressures.[14] In addition to the findings of bruits over the root of the neck by physical examination, patients did complain of central nervous system insufficiency such as visual disturbance, extremity weakness, dizziness and ataxia. However, the correlation with what today would be termed an associated "subclavian artery steal" with retrograde vertebral artery flow was not appreciated. Angiographic study even as recent as the 1950s was not sophisticated enough to demonstrate the exact nature of flow through the aortic arch vessels.

Pathologically syphilitic involvement of aortic arch vessels such as a subclavian artery may be produced in several ways. Syphilitic disease in the proximal portion of a subclavian artery may be merely an extension or continuation of the changes produced in the aorta; i.e., involvement of the vessel with syphilitic mesarteritis, intimal proliferation and subsequent stenosis of the artery. In addition, distinct syphilitic arteritis has been described to involve extremity arteries associated with fibrous proliferation of intimal and medial elements resulting in obliteration of vessel lumen.[15]

Clinically, several explanations are suggested to interpret how syphilitic lesions might cause aortic arch vessel narrowing such as that of one or more subclavian arteries without actually causing demonstrable pathologic changes in these vessels. It has been suggested and confirmed by postmortem studies that antemortem thrombus may extend from a syphilitic aneurysm involving the arch into the vessel lumen with occlusion of innominate, common carotid or subclavian arteries.[16] In addition, an expanding aortic arch aneurysm may tend to compromise the flow through arch vessels such as the subclavian artery but would not necessarily cause a fixed, marked obliteration of vessel lumen.[17]

As noted previously, a vessel such as the subclavian artery may indeed be involved with classical syphilitic endarteritis.[18] The luetic lesion with intimal thickening and irregularity predisposes the vessel lumen to further insult with the deposition of atheromatous deposits and the potential, therefore, to cause a significant stenotic lesion. Syphilis, involving the left subclavian artery with significant obstruction of the vessel lumen, cannot be excluded as an etiologic factor in producing the clinical symptoms described in case 2.

Surgical correction of symptomatic proximal subclavian artery obstruction has been carried out since 1958. Currently at least two techniques are utilized in the majority of patients; namely, transthoracic proximal subclavian thromboendarterectomy and carotid-subclavian artery bypass grafting.[19] Most medical centers do not presently advocate surgical intervention of subclavian artery obstruction in an symptomatic clinical setting. One reason for this restraint is lack of knowledge regarding the natural history of proximal subclavian artery obstruction. It is conceivable, however, that once such additional information is obtained, more obstructing lesions will be surgically corrected.

It is stressed that both surgeons and medical practitioners continue to evaluate carefully those patients who present with symptoms of painful upper extremity or episodic complaints suggesting cerebral vascular insufficiency. The underlying cause of the problem may indeed be proximal subclavian artery obstruction. The simple performance of recording blood pressure in both upper extremities in all patients may be quite rewarding in establishing the diagnosis of this potentially reversible condition.

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Editorial Comment by Daniel B. Nunn, M.D.

In the presence of unilateral subclavian arterial occlusion, the radial pulse in the effected extremity is not only diminished but also may be intermittently detectable and asychronous with respect to the pulse in the opposite extremity.

The transthoracic surgical approach for correction of subclavian arterial stenosis or occlusion (used in Case I of this report), has generally been discarded in favor of extra-thoracic bypass grafting which is associated with a lower operative morbity and mortality. The extra-thoracic procedures commonly performed are carotid-subclavian artery bypass and axillary—axillary artery bypass utilizing either dacron or autogenous vein grafts.

Biofeedback

When Medication is Not Enough

Philip C. Rond, M.D.

Abstract: The aim of Biofeedback therapy is to help the tendency of the autonomic nervous system (sympathetic-parasympathetic balance) to a balance conducive to healthier body functions. It is both a preventive and therapeutic approach. It is recommended for the patient whose illness is stress generated, functional, psychosomatic.

Biofeedback is the instant and continuous monitoring of body functions with special electronic instrumentation. It is as the term implies the feedback of signals of biological activities.

Biofeedback is a form of therapy for existent psychosomatic illnesses; it can also be a preventive approach. The technique is aimed at returning the autonomic nervous system to a state of balance. This type therapy should be considered when the patient's response is insufficient to prescribed medication, when a moderate amount of medication fails to carry the patient symptom-free or relatively so; when there is an indication for discontinuing medication or for not starting it in the first place.

A discussion of the autonomic nervous system's role in producing tension and psychosomatic illness will put into perspective what biofeedback therapy can do to help restore a state of health to the patient.

The autonomic nervous system receives its first imbalancing charge at birth. Then with growth and development the child/adult with its individual genetic endowment is predisposed to react its own special way in developing a variety of syndromes (from mild to severe). These range from relatively unsomatized symptoms such as simple anxiety to more predominantly and primarily somatic disorders. As the sympathetic division of the autonomic nervous system inappropriately exceeds the parasympathetic and with increase in the duration and intensity of this dominance, psychosomatic disease may develop. The patient then seeks attention.

The physician may diagnose the condition as a tension syndrome and prescribe the usual medication. In many patients the symptoms subside, and the autonomic nervous system is restored to balance. The patient becomes stabilized. In some, however, the balance is not quickly restored; the physician then begins to look further for help; biofeedback may have something to offer him.

Illustrative Case

One such patient is a 41-year-old widow with a 17 year history of severe, classical migraine, who often required heavy doses of analgesics daily. Many approaches to resolution of the condition were tried including psychotherapy without success. She finally succumbed to utilizing enough drugs so that she would be relatively free of pain. This created concern that she was becoming an addict. She did not give up hope of finding permanent relief. When biofeedback was recommended, she accepted referral readily.

Dr. Rond is Director of the Division of Mental Health at the Florida State University Health Center in Tallahassee.

Treatment was begun on a day when she was relatively comfortable. This is important since the training method requires concentration on the monitor signal. She was attached to a Temperature Trainer which uses a sensor (thermistor) connected to the fingertip. This monitors skin temperature as an indicator of peripheral vascular dilatation.

The treatment consisted of training her, through conscious effort, to warm her hands at will, quickly and easily. To her surprise she learned to do this with four treatments lasting approximately a half hour each. Now, upon sensing initial headache prodomata, she warms her hands. She has been free of migraine pain for seven months.

Discussion

The training program and management is best administered in cooperation with the referring physician. This is particularly important at the onset and until the patient has had a positive response to the therapy and is ready to reduce medication. The particular type of therapy implemented depends upon the body system affected, as a concomitant of the anxiety being generated. Since muscle tension is present in most anxiety states, initially many psychosomatic conditions may be treated with electromyogram (EMG) biofeedback.

This procedure is directed at training the patient to relax the skeletal muscle system whether at work or rest. When this is successful, a circular reenforcing source of autonomic sympathetic stimulation is eliminated. Then, one of the other biofeedback therapies may be applied to a more specific syndrome, which often will have been eliminated by the initial therapy. Essential hypertension is a symptom complex known to respond to electromyogram biofeedback.

Biofeedback therapy requires the ability of the patient to focus inwardly. Too much distraction from pain or psychological disorientation renders the process inoperable. So timing in relationship to the beginning of treatment is important, particularly in those patients taking medications. It is also important to begin therapy before the symptom complex becomes fixed, a source of secondary gain, and/or a part of the character defenses of the patient.

The therapy requires a number of training sessions to establish the desired control, and practice by the patient until control becomes a habitual manner of response. The result is a built-in procedure which is preventive in nature—a self-generated mechanism to prevent psychosomatic dysfunction.

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▶ Dr. Rond, 2210 Killarney Way, Tallahassee 32303.

Research Grant Applications Being Accepted

The FMA Committee on Research will accept until October 30 applications for Florida Medical Foundation research project grants. Approximately $19,207 is available this year for grants. Application forms and other information may be obtained by contacting: Research Committee, FMA Headquarters, P. O. Box 2411, Jacksonville, Fla. 32203.

Prefabricated Silastic Subdermal Implants for Facial Reconstruction

Mutaz B. Habal, M.D.

Abstract: A technique is described in which a prosthesis for subdermal implantation is prefabricated from raw silicone rubber (Silastic). The implant is biocompatible, firm, and produces an acceptable result when used to replace or augment missing or deficient parts of the osseous framework in the facial region. In selected patients, and patients who have undergone resection for tumor, the results are gratifying.

Rehabilitation of the patient who is a social cripple due to severe facial deformity is counted among the difficult tasks. Any improvements or advances offering assistance usually are well adopted by the practicing physician. Considerable promise in reconstruction procedures was shown by the silicones produced by biomedical material engineers in the last decade. Successful results obtained in other parts of the body encouraged the utilization of prostheses made from them in reconstructing the facial region.[1-3] The initial uses, however, failed to measure up to expectations.

Since the defect in the facial region had to be made to fit the commercially available prostheses, custom fabrication with a biocompatible material, Silastic,* for the particular defects offered the solution.[3,4] Silastic is a polymer of dimethyl siloxane, and the degree of polymerization produces a variety of different grades of silicone varying from the liquid injectable to silicone gel used in breast prostheses and silicone rubber.

From the Department of Surgery (Plastic Surgery), University of Florida College of Medicine, Gainesville.

This presentation is based upon the scientific exhibit, "Silicone subdermal Implants for Facial Reconstruction," shown at the Florida Medical Association's 101st Annual Meeting in Bal Harbor, April 24-26, 1975.

Dow Corning Corp., Midland, Michigan.

Fabrication

Custom fabrication of the subdermal implants can be done in the well-equipped prosthetic laboratory usually available in most hospitals. The first essential is an accurate measurement of the defect. This is accomplished on the facial moulage, panographic x-ray of the mandible, cephalogram, and dental occlusal model.[5]

A wax model is made of the part to be reconstructed and tried on for external fix. The wax is placed in a stone to produce a negative impression. Raw Silastic is placed in the stone model which is put into a pressure oven. It flows under the pressure and is polymerized with heat. The prosthesis is vulcanized and cured in an oven at 400 F. When removed from the stone, it conforms to the desired shape and form. The prosthesis is washed under clean room conditions, flash autoclaved for ten minutes and inserted surgically in the operating room. The implant is fixed to the bone with stainlesss steel wire and to the soft tissue by addition of Dacron felt on its inner surface (Fig. 1).

Application

The implants are used in two categories of patients: children with congenital deformities and adults with acquired deformity usually either sequelae of trauma or postresection for tumor.[6] Patients with deformities are candidates, however, whether due to deficiency or absence of parts of the architectural framework of the face. The most important factor in success of the "pseudo take" is presence of adequate soft tissue for coverage.

Children with congenital deformities have tight tissue spaces. They also are deficient in soft tissue and their skin is very elastic. Under these circumstances, the implants are found to be un-

successful and we do not recommend their use.[2] Correction in children is accomplished with osteotomy and repositioning of the segments with bone graft augmentation.[7]

In patients whose deformity is due to sequelae of trauma, the implants usually will correct the osseous framework deformity. The results are very satisfactory.

Patients who benefit most are those who have had resection of the osseous framework in the face due to presence of a tumor. Such deformity is more pronounced when it is in the mandibular region. Correction with alloplastic implants has produced most gratifying results. The patient who is initially very frightened from the expected deformity usually is very content with the final result and feels possessive of the implant in view of any suggestion regarding revision.

The patient whose deformity is due to post-resection for malignant disease may have the initial reconstruction right after the resection or wait for a disease-free period. The latter is recommended in instances where there is a highly malignant disease or doubt about the presence of free margins of resection. This late reconstruction is done 18 months post-tumor resection. A few patients may require soft tissue augmentation prior to implantation.[8] The implants may be permanent or temporary.

Complications

The most common complication is presence of clear fluid around the implant which has been decreased in incidence by a change in autoclaving procedure from "gaz" to flash. The ethylene oxide used in "gaz" autoclaving adsorbs on the surface and causes the tissue reaction. Presence of "hematoma" can be minimized by adequate hemostasis prior to closure. The most grave complication is extrusion of the implant. This is due primarily to presence of inadequate soft tissue for coverage. Infection has not been a problem; all patients receive the appropriate preventive antibiotics.

Fig. 1.—The different sizes and shapes of Silastic mandibular implants. Note the decrease in vertical height and presence of multiple fenestrations which allow the ingrowth of fibrous tissue, thus adding fixation to adjacent soft tissue structures.

Comment

Success depends upon the facial region being reconstructed. In static regions such as the forehead or maxilla, success is imminent. In dynamic regions such as the mandibular, success usually is guarded by the age of the patient and the dynamic forces of the musculature on the implant. The overall success rate is about 85%.

The silicone rubber is well tolerated in the facial region, it is inert, nontoxic, noncarcinogenic, nonallergenic, and there is no soft tissue reaction around it. Its mechanical and physical properties are well suited for use in the facial region. It is well tolerated by the soft tissue because of its smooth surface. Its physical properties are superb, it withstands shock, and trauma, and does not shatter or break. The Silastic implant is elastic, yet firm enough to withstand the dynamic forces of the facial musculature. These properties make the Silastic implant ideal for use in selected patients in restoring any given deformity.

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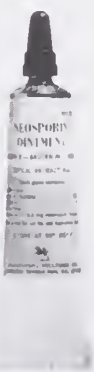

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Special Articles

Peer Discipline: We Have the Tools

George S. Palmer, M.D.

In the July 1975 issue of *The Journal of the Florida Medical Association,* FMA President Vernon B. Astler, M.D., devoted his monthly page to the matter of the "sick doctor," pointing out clearly how effectively they can be dealt with by the Board of Medical Examiners, assisted by organized medicine.

Florida has been the leader in this field since July 1, 1969, when the nation's first "sick doctor law" became effective in this state. This obviously was a giant step forward in providing the medical profession the means for keeping its own house in order.

So much for the "sick doctor." Now, what about the medically or professionally incompetent physician? This is the fellow who just hasn't kept up with progress and the rapid technological and scientific advances in medical practice.

Characteristically, he doesn't read, attend lectures, meetings or seminars; he uses old methods and procedures of questionable value; he orders or uses unnecessary drugs or diagnostic tests; he shows a pattern more directed toward quantity and profit rather than quality and good results. On the technical side, he shows signs of loss of touch and necessary skills; lessening of good judgment or recommending and performing surgical procedures without good reasons, with questionable therapeutic results and without adequate consultation.

What can we do about this fellow whose nagging presence and actions reflect negatively on our profession? Up to now, the answer has been little or nothing. Good physicians have been reluctant to move against bad ones for fear of becoming involved in a retaliatory lawsuit, and a general hesitancy to charge a fellow physician with incompetence or question his practice in any effective way.

But times have changed. There have been shifts in public attitudes, court rulings, and public education. The age of consumerism demands that he who offers his products or services for pay measure up to an acceptable standard. Physicians are not exempt from these demands.

In recent years we have witnessed increased demands for health care as a right; increased knowledge and publicity concerning surgical and medical conditions; increased emphasis on accountability for medical practitioners; increased expectations of near perfection in results of treatment; increased costs of health care; and increased involvement—and meddling—of idealistic planners and do-gooders in medical affairs.

All physicians are expected to provide care on a level compatible with their education, background and expertise in their particular specialty. Idealistic and often unrealistic demands and pressures for perfection cure, immortality, sexual proficiency and happiness, along with freedom from illness, pain and any departure from the norm; and the inevitable depersonalization of relations between patient and physician have resulted in the recent and continuing crisis in professional liability insurance, among other things.

Dr. Palmer is Executive Director of the Florida Board of Medical Examiners.

In addressing the professional liability problem, the 1975 Legislature amended the Medical Practice Act in such a way to allow us to deal effectively with the medically or professionally incompetent doctor. I say "us" because it will take both organized medicine and government, through the Board of Medical Examiners, to accomplish the objectives. Generally, the new amendments authorize the Board to act against a physician who, after hearing, has been adjudged unqualified or guilty of any of the following: immoral or unprofessional conduct, incompetence, negligence or willful misconduct.

Unprofessional conduct shall include:

—Any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice in his area of expertise as determined by the Board;

—Being found liable for medical malpractice or any personal injury resulting from an act or omission by a person in his capacity as a licensed physician;

—Being removed or suspended or having disciplinary action taken by his peers within *any* professional medical association, society, PSRO, or similarly constituted body, whether or not such organization is local, regional, state, national or international in scope; and

—Being disciplined by a licensed hospital or medical staff.

Any such action must be reported to the Board within 30 days of its occurrence under penalty. The Board may deputize any one or more licensed physicians to assist in investigating the conduct or competence of a physician. The following section of the new law is important:

"There shall be no liability on the part of, and no cause of action of any nature shall arise against the Board, its agents, its employees, or any organization or its members identified in paragraph (p) of subsection (1) of this section, for any statements made by them in any reports or communications concerning an investigation of the conduct or competence of a physician."

In a finding of guilt against any physician, the Board may order any of the following:

—Deny his application for a license;
—Permanently withhold issuance of a license;
—Administer a public or private reprimand;
—Suspend, limit or restrict his license to practice medicine for a period up to five years;
—Revoke indefinitely his license to practice medicine;
—Require him to submit to the care, counseling, or treatment of physicians designated by the Board;
—Require him to participate in a program of continuing education prescribed by the Board; and/or
—Require him to practice under the direction of a physician in a public institution, public or private health care program, or private practice for a period of time specified by the Board.

All this gives us the means to take another giant step forward in keeping the House of Medicine in order for the protection of the public. The Board of Medical Examiners has but five investigators, but 12,000 licensed physicians in its jurisdiction. Obviously, the Board cannot be expected to do all alone with regard to case finding, hearings, disciplinary actions, rehabilitation and disposition of M.D's requiring attention. Organized medicine, each licensed M.D., each organized hospital or clinic staff, each medical organization of any size must be ready, willing and able to do his or its part.

Ideally, case finding and remedial action should be accomplished locally and without delay. Each licensed M.D. now has the support of the law and the cloak of immunity when he is serving in good faith and without malice, whether individually, as a member of any group of his peers, or as an agent of the Board.

If a problem M.D. cannot be handled by his peers locally or on the state level, he can be referred to the Board of Medical Examiners for action, which may put his license in jeopardy. The facts should be gathered and available, and witnesses ready and willing to testify to afford due process.

Remember that each of us is Our Brother's Keeper. Each of us also is a custodian of the House of Medicine, and we are responsible for keeping it in order. If we don't rise to this challenge, who will?

▶ Dr. Palmer, 305 Blount Street, Tallahassee, Florida 32304.

Note: For a copy of the amendments to the Medical Practice Act discussed in this article, write to: Law Division, Department of State, The Capitol, Tallahassee, Florida 32304, and ask for 75-9.

Our Golden Opportunity

William W. Thompson, M.D.

In the 1970s organized medicine has had to play the heavy for increasing public criticism about how medicine conducts its affairs. Most of us commonly hear such comments as "Why do you let so-and-so practice when you know he is no good," "The medical society is covering up for Dr. so-and-so," and "The lawyers police their profession better than you do."

If there is any element of truth to such accusations, it has probably been due in part to the lack of adequate legislation to deal with the medically or professionally incompetent doctor and a hesitancy on the part of the white hats to become involved in something that might pull them into a law suit.

In the preceding article, Dr. George S. Palmer, Executive Director of the Florida Board of Medical Examiners, writes about new legislation that alleviates these concerns. Now it appears that Dr. Palmer's Board and organized medicine have the clout they need to interfere with the doctor who is not necessarily sick of mind or body but whose professional performance is dangerously and chronically substandard or worse.

Dr. Palmer makes a special appeal to organized medicine and licensed doctors individually to help his understaffed board to identify the few among the 12,000 of us who are wanting professionally, to get them back on the track if we can, and to report them to the Board if we can't.

There is, of course, nothing new about cooperation between the Board and the Florida Medical Association, with the FMA Judicial Council and its subordinate Committee on Membership and Discipline. Largely through the efforts of one of my predecessors as Chairman of the Judicial Council, the venerable Dr. John C. Cheleden, the Committee on Membership and Discipline has evolved as a valuable asset to the Board in its investigative functions.

Since the "sick doctor law" was written into the statutes in 1969, the Board of Medical Examiners has from time to time commissioned individual members of the Committee to conduct disciplinary investigations. The job is almost never pleasant. It requires time out of the office and away from patients. And no pay accrues to the physician-investigator except for the satisfaction that he has rendered his profession and the public a service.

What are we trying to do? What do we try to accomplish when we bring the sick doctor or the professionally incompetent doctor under scrutiny? Are we out to wreck his career? Or do we keep him out of circulation for a while until the cloud blows over?

The protection of the public from the menace or threat of an unqualified or mentally or physically disabled practitioner is a prime consideration. But if there is a chance that the man might be shown the error of his ways and restored to useful service some day, that must be taken into account. Since no two cases are exactly alike, the Board has a wide range of courses of action, from reprimand or probation to license revocation.

In addition to protection of the public and rehabilitation, there is a third consideration, and that is the protection of the dignity and honor of the profession. Bringing the errant practitioner to terms and making him mend his ways if it is possible to do so removes a blight on all of us.

The new law provides that the Board may deputize any licensed physician to conduct investigations. But before it comes to that, it is the responsibility of each physician to report incompetent physicians. To those who prefer not to do so for fear of possible legal entanglement, here are the words of the law:

"There shall be no liability on the part of, and no cause of action of any nature shall arise against the Board, its agents, its employees, or any organization or its members identified in paragraph (p) of subsection (1) of this section, for any statements made by them in any reports or communications concerning an investigation of the conduct or competence of a physician."

As stated in the title of Dr. Palmer's article, we have the tools to do the job of peer discipline. We should view this as our golden opportunity to keep the House of Medicine in order.

▶ Dr. Thompson, 137 Hospital Drive, Fort Walton Beach 32548.

Dr. Thompson is chairman of the FMA Judicial Council.

Medical Care for Children
Concepts of Regionalization

Henry G. Morton, M.D.

As the Regional Medical Director for the Sarasota area of the Division of Children's Medical Services, I have had the opportunity to formulate some thoughts on the regionalization of medical care for children, particularly those with special problems.

Regional boundaries having medical care delivery implications should follow county lines as much as possible because of political differences. In deciding upon limits of these areas, population masses should be the next consideration. A region encompassing less than 300,000 people would hardly be feasible. Adequate hospital facilities are mandatory, including pediatric wards with necessary facilities and associated medical staff expertise. Regional lines should be drawn so that families and patients have relatively easy access to services, as transportation is a major consideration.

Some areas of the state presently have neither a clinic nor a hospital that is linked with the Division's medical program for children. The need for such a clinic will increase with a gain in population. This, in turn, will attract the necessary interested and qualified physicians. Thus, a potentially sufficient caseload of patients in a region is necessary to justify the establishment of a new clinic. Furthermore, a viable pediatric unit in a general hospital should have a minimum daily census of 15 patients. To further fragment and divide the currently existing regions could be fatal. There would be too few patients; and many hospitals would have an inadequate number of children to insure a well-functioning pediatric service.

Since living standards and per capita income vary, a higher ratio of need to services can be anticipated in economically depressed areas. Roughly in an area of 300,000 people there will be approximately 100,000 individuals under age 21. About one of every 50 will need the specialized health care provided by the Division.

The clinic caseload varies considerably according to the service offered; that is, whether all-encompassing evaluation and treatment is provided or whether one aspect is considered. The latter situation gradually is giving way to the concept of total care, but specialty clinics remain important. For instance, in a community of 300,000 people, about 3,000 children will be born each year. Statistically about 24 of them will have congenital heart disease. In eight the cardiac condition is critical within the first year. Over a period of years several hundred heart patients will need particular specialty care. Certainly this number is sufficient to justify the establishment of a new special clinic.

Continuity of care is important in considering regionalization. In the setting of the general clinic, patients seldom get lost. They are examined and advised with each individual chart and all consultation reports in hand. Most important, easily available advice can be received from the other physicians attending this clinic. To me, this is the only possible way that continuity of care can be maintained. Imagine the confusion that would exist without the clinic setting. The patient and his records would need to be sent to other clinics, physicians' offices and hospitals. There could also be a waiting for reports, wondering who had the chart, where the child is, who is doing what treatment, who sanctioned it, and what charges are being made. Worst of all, no one would know who is directly responsible for the overall care of the child.

A boy under my care illustrates this situation. The child appears to spend more time in the hospital than anywhere else. Someone is constantly doing something new to him. He is now three years old, but has never visited the clinic. Although the bills are paid, a routine is established which convinces me of the futility of this approach.

Ultimate responsibility is a factor in the regionalization of children's health care programs. A medical director should be in charge. His responsibility would include keeping the mechanics of medical care delivery functioning efficiently,

to decide upon changes in policies and directions, and to maintain adequate fiscal standards. His opinion would be sought regarding the formation of subdistricts and the establishment of new clinics for special services. This would prevent fracturing the area with the associated implementation of multiple small inefficient clinics. An assistant medical director would be consulted frequently and be kept well informed, ready and able to carry on the work as necessity demands.

Each of the general pediatric clinics should engage in diagnostic evaluations, with the thought in mind that our first obligation is complete care. All aspects must be investigated, diagnosed and treated. Thus, a balanced program should be our goal, one that takes the entire child into consideration.

In any region, a good working relationship with all physicians in all specialties is a necessity. The referring physician must be informed of the patient's progress; and copies of all clinic reports should be sent to him. There should be no competition between various patient care services. Our relations with public health disciplines is of utmost importance, and the staffs of the county health departments must be kept informed. They are our most frequent casefinders, and we are indebted to them. There must be adequate cooperation with the staff of the Division of Vocational Rehabilitation, particularly as the child becomes older and would profit from their specialized services.

In the Sarasota region, the problems are many and diversified. Yet somehow, the child's medical care continues. To multiply these problems with involved hospitals and consultants in every town would produce a horrendous monster. Complaints would spring from every patient, physician and hospital. The spirit would be lost that has made this system work. Thus, a central clinic, both to control and coordinate care and to evaluate patients, is essential to maintaining superior child care.

Regionalization has many aspects and many facets. More problems will evolve with time. Paramount is the thought that we physicians for children are doing this work for one who cannot speak effectively for himself.

▶ Dr. Morton, 1950 Arlington Street, Sarasota 33579.

Editorial Comment by Joseph G. Matthews, M.D.

Dr. Morton's article touches on many of the important considerations of regionalization and also the "clinic concept," which has worked effectively over the years, particularly for the care of the medically indigent children. The medical care of this category of patient should not be compared with the care provided the private patient in the private physician's office.

This article should also stress the teaching values derived from patients having similar medical problems that are seen, followed and treated in specialty clinics. This teaching experience is particularly valuable for residents, medical students, as well as attending physicians. The team concept which is used in many of the CMS clinics is also a very valuable device for providing on the spot expertise to a child that may have multiple problems. If the CMS sponsored patient was to be farmed out to individual physician vendors, the system would not collapse but would simply deteriorate.

The Rehabilitation Counselor

Mary Lou McEver, Ed.D.

Abstract: When a patient's disease, accident or congenital impairment results in a disability which requires a change in life style or employment, the counseling and intervention services of a rehabilitation counselor may be of value to the patient.

Although the majority of trained rehabilitation counselors work for the Division of Vocational Rehabilitation and in that role are involved in implementing the delivery of services funded by the state agency, it is hoped that physicians have been curious about the skills and knowledge of these individual counselors themselves. Rehabilitation counseling is a profession in its own right. The article presents information about the activities of the counselor, the education and background of counselors and proposes closer working relationships between physicians and counselors for the rehabilitation of people who are handicapped by their disability.

Do you have these patients in your practice?

A 42-year-old man who has had two heart attacks and will not relinquish management of his stressful business;
A mother who is extremely anxious about the return home of her son who has been in prison and who both need reassurance;
A skilled hairdresser whose hands are growing stiff from progressive arthritis; or,
An adolescent whose hemophilia has been followed by you since his birth and who is now asking you for advice regarding career plans.

There is a specialist in the community who can help such patients who desire for themselves as full a life as possible in spite of limitations imposed by impairment. A rehabilitation counselor is available for referral or consultation but is often overlooked as a resource. Yet this professional person is potentially helpful to your patients who are seeking satisfying solutions or adjustments to stressful barriers (employment considerations being one).

The objectives of this article are to introduce you to the profession of rehabilitation counseling, to provide information about the activities of the practitioners, and to indicate how physicians and counselors can link their respective skills in the interest of people with serious problems.

Some physicians in Florida already know of the existence of rehabilitation counselors, having been associated with those who work for the state agency, Division of Vocational Rehabilitation (DVR). This relationship may have been limited to exchanges of DVR forms or reports on medically indigent people with disabilities leading to the assumption that these DVR counselors work only with medically indigent disabled persons. A few physicians do know of counseling as it presently exists. Quite apart from the agency setting in which many specialists in rehabilitation work, these counselors have skills which any patient with a disability may need.

What Does the Counselor Do?

Realities of today must be visualized in light of their meaning for the future. This is where the counselor begins.

Consider a typical situation in which the counselor may be involved in the multitude of activities for one of the four patients described, for example, the patient with arthritis. First, the counselor will interview the individual drawing out her feelings of stress which result from the realization of the progressive nature of her disease and the uncertainty of her future which requires change in lifestyle. Together the counselor and patient plan a series of steps which will lead to a satisfactory change in her career.

For assessment of limitations and potentialities, the counselor may analyze the work history for clues to prospective job choices or may give tests to identify skills, interests, or personal and intellectual assets. In determining physical function, the counselor may synthesize the medical information you provided or may discuss the patient's prognosis with another physician or specialist such as an orthopedist or internist. Should training for new skills be indicated contacts could be made with a college, rehabilitation center or business school depending on the objective. For special need services, there could be contacts with a social worker, public health nurse,

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housing project manager or relative. Later in assisting the client in finding alternative employment, contacts are made with a varied group of businesses which have positions that need these assets and supervisors who are not bothered by disablement.

Many options and directions are considered in each situation. The seasoned counselor knows that each situation is unique because the people who are being influenced by the situation are unique. Therefore, each individual client requires services, activities and involvement which will differ from every other client. The extent of services is determined by each setting in which the rehabilitation counselor works . . . DVR agency, sheltered workshop, hospital, mental health clinic or prison. Policies of the agency vary. However, in each of the settings, the rehabilitation counselor can be quite flexible in working with individual clients toward mutually agreed upon objectives. A knowledgeable and imaginative counselor who is capable of being sensitive to where the client wants to begin effectively determines the outcome of the client.

What is Included in Training?

The professional counselor emerged in the history of rehabilitation in response to the need for someone in the community to monitor the process from disablement to satisfactory employment adjustment. Skills for the profession were drawn from medicine, vocational guidance, psychology, education, social work, industrial engineering and sociology.

Professional training for rehabilitation counselors was initiated in the 1950's with Vocational Rehabilitation Administration assistance to several universities. Graduate departments of psychology, counseling, social work and special education housed the training programs. There are now approximately 75 rehabilitation counselor training programs, many of which are independent departments in universities.

In Florida, there are three graduate education programs for rehabilitation counselors: University of Florida which is in the College of Health Related Professions; Florida State University's program in the College of Education; and the University of South Florida where the program is in the College of Social and Behavioral Sciences. In each case, the housing of the program is in a college which will accept an interdiscipline curriculum and provide for clinical practice. The University of Florida's Department of Rehabilitation Counseling was the first training program in the southeast.

The coursework for prospective counselors includes information about the field of rehabilitation, nature of disablement, research, assessment of individual differences, understanding personality development, processes of counseling, job analysis and placement, medical, social and psychological aspects of disability. Field practice is a particularly important part of the curriculum.

In each of the rehabilitation counselor education programs, there is a course offering on medical information through which the student is introduced to significant information about the various body systems and the functional complications imposed by specific impairments. In the program at the University of Florida, the medical specialists from the College of Medicine participate in this medical survey course. Extensive medical information is made available to the students. Important to the students' learning is their understanding of the etiology of disability and their development of skills for drawing vocational implications for counseling. Important, too, is their need to be familiar enough with disability that their question to the medical specialists will produce clear information for service to clients.

The students in their training have practical experience in working with disabled persons in clinical settings such as Shands Teaching Hospital, Veterans Hospital, Correctional Programs, Sunland Training Center, sheltered workshops and other community service programs. Practicums and internships provide for the increasing levels of responsibility. Should the students want to follow special interests, they may take courses in mental retardation, drug abuse, psychopathology, criminology and juvenile delinquency.

Counselors trained in the graduate programs come from a variety of backgrounds and undergraduate study. Some students are pursuing second careers, others come into the program directly from undergraduate school. Although the majority have degrees in the behavioral sciences, many excellent counselors have backgrounds in the physical sciences, economics, English or education. The ratio between men and women in the profession at this point is nearly balanced. In assuming multi-roles which are determined by the multitudinous problems of disabled persons, rehabilitation counselors have to be extremely adaptable, yet they must be self-disciplined enough

to establish and accomplish objectives with those whom they serve.

What is the Status of the Profession?

At present, most rehabilitation counselors work in public or private supported agencies although a few have established themselves in private practice. The majority are employed by the Division of Vocational Rehabilitation.

Some counselors prefer to specialize with a particular problem group such as those with mental disturbances, spinal cord injuries, mental retardation or drug offenders. Even with specialization, the training is comprehensive so they may function as a catalyst for people with serious disabilities whatever the disability may be. Knowledge of disablement must be broad because prisoners have heart problems, retarded persons have amputations, and drug offenders can become paraplegic.

For the purpose of establishing ethical and performance standards for the profession, the National Rehabilitation Counseling Association is now involved in the implementation of certification for rehabilitation counselors. Required will be education, experience, and examination for the purpose of establishing credentials for practice which would have purpose in the protection of clients served. Credentials are long overdue inasmuch as rehabilitation counselors have serious responsibilities in their relationships with persons with complicated needs.

How Does the Counselor Relate With the Physician?

Counselor-physician relationships develop through the agency referral of patients to you for examination or treatment or through your referral of patients to an agency for service. All clients of the DVR agency are required to have a general medical examination.

The information which rehabilitation counselors seek from physicians through examination has several purposes. At one level, the medical diagnostic information describes the functional limitations and prognosis of the disabling condition. If the disability can be reduced by treatment, the regime is proposed. The agency policies would determine if financial payment for care would enter the planning.

At a more comprehensive level, the diagnostic information from the physician establishes the physical well-being or general state of health of the client. Such information identifies secondary problems or confirms the general stamina of the client. This information provides added insights for the counselor who already has some background training in understanding the medical aspects of disability.

For those clients who are referred to you by a Vocational Rehabilitation agency, the examination through you may actually be the first physical ever experienced by many clients. Certainly for the increasing number of adolescents who are now seen by rehabilitation counselors, this introduction to medical care would seem important for lifetime application. The teenager who is introduced to his body systems may be more alert to symptoms of distress, not to mention his willingness to seek preventive rather than crisis care.

For counselors at the Division of Vocational Rehabilitation, a medical consultant meets with them weekly to provide clarification of the extent of disability and medical treatment procedures. Although the medical consultant is a most valued colleague, it is the counselor's responsibility to visualize the relationship of the limitations of the client to vocational objectives.

Those counselors who are knowledgeable of medical aspects of disability, having studied this in their training, can be an asset at the treatment level. They quickly recognize when something may be amiss in the patient's progress or in descriptions of an examination and can relay this to the physician. There are times when the patient has not understood the physician's advice or has misinterpreted this advice. In consultation with the physician, the counselor can often clarify instructions without the patient returning to the office and consuming more time. Should a return visit be indicated, the counselor alerts the physician so that clarification of the misunderstanding can be accomplished easily.

Whether the patient is referred to you by the counselor or the patient is referred to the counselor by you, the counselor may share insights regarding some of the extenuating circumstances in the client's life which are operating apart from the medical regime yet which can have a detrimental effect on the medical treatment itself. Accepting the fact that many individuals do have a very natural and acceptable reaction of frustration to the trauma of disablement is a part of counselor's training. The counselor's knowledge of the process of adjustment and his familiarity with the client's feelings regarding limitations could be helpful to the physician in treatment.

Community Involvement

Rehabilitation counselors extend their interest in disablement beyond the individual services which they render to their individual clients. Being acutely conscious of the impact of disablement in all phases of life, rehabilitation counselors often become active participants in various community health and civic organizations. The local, state, and national boards of voluntary health organizations such as the Heart Association, Easter Seal Society, Association for Retarded Children, and Mental Health Association list rehabilitation counselors among their members. Through these associations, the counselors work with other professionals in bringing knowledge to the solution of communitywide problems. The counselor's close association with the final stages of recovery and rehabilitation is valuable information for program planning. This accumulation of knowledge in the field can be applied towards the prevention or reduction of disablement.

In summary, disablement is a personal problem with many ramifications which concern many disciplines. There are different degrees of impact on the person disabled which determine the involvement of the disciplines: (1) even though not severe, disability can be a persistent bother to the person disabled; (2) should the impairment interfere with the usual every day activities or employment, it becomes a nagging inconvenience to the person disabled; and, (3) if it prevents those activities or if it terminates employment, disability is a serious problem for the individual.

Finally, and most critical to all of us, should the disabling problem become complicated by prejudice or the indifference of others, disability becomes a tragic disaster.

Whether disablement is a result of birth disorders, chronic disease, accident or deprivation, the people affected need a variety of resources for the varied levels of limitation. The physician, of course, is the first. All patients look to physicians for guidance when disability occurs. Should a change in employment be indicated and you feel limited in career counseling, the rehabilitation counselor may be the consultant you and your patient need. The rehabilitation counselor in the DVR agency, hospital, or other settings also has skills which can help assure patients of as satisfying a life as possible.

▶ Dr. McEver, J. Hillis Miller Health Center, Box 756, Gainesville 32610.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Lomotil is contraindicated in children less than 2 years old.

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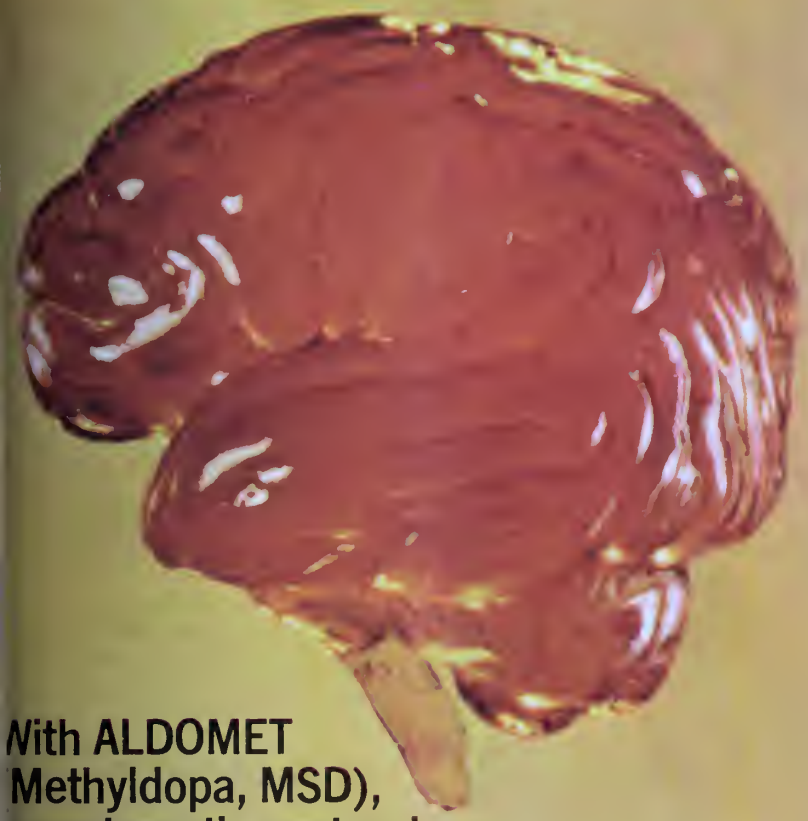
ALDOMET has no direct effect on cardiac function. When ALDOMET is used in effective doses cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is slowed.



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For hypertension

TABLETS, 250 mg, 500 mg, and 125 mg

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ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is not recommended in pheochromocytoma.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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For a brief summary of prescribing information, please see following page.

addendum

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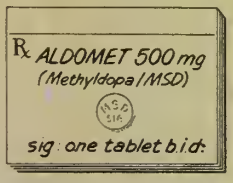

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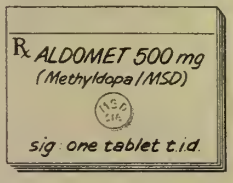

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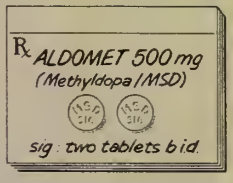

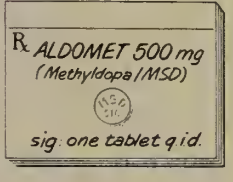

NOTE: Tablets shown are not actual size.

in hypertension

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usually lowers blood pressure effectively

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reaction or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by the procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, involuntary choreoathetotic movements, psychic disturbances including nightmares and reversible mild psychosis or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, skin rash.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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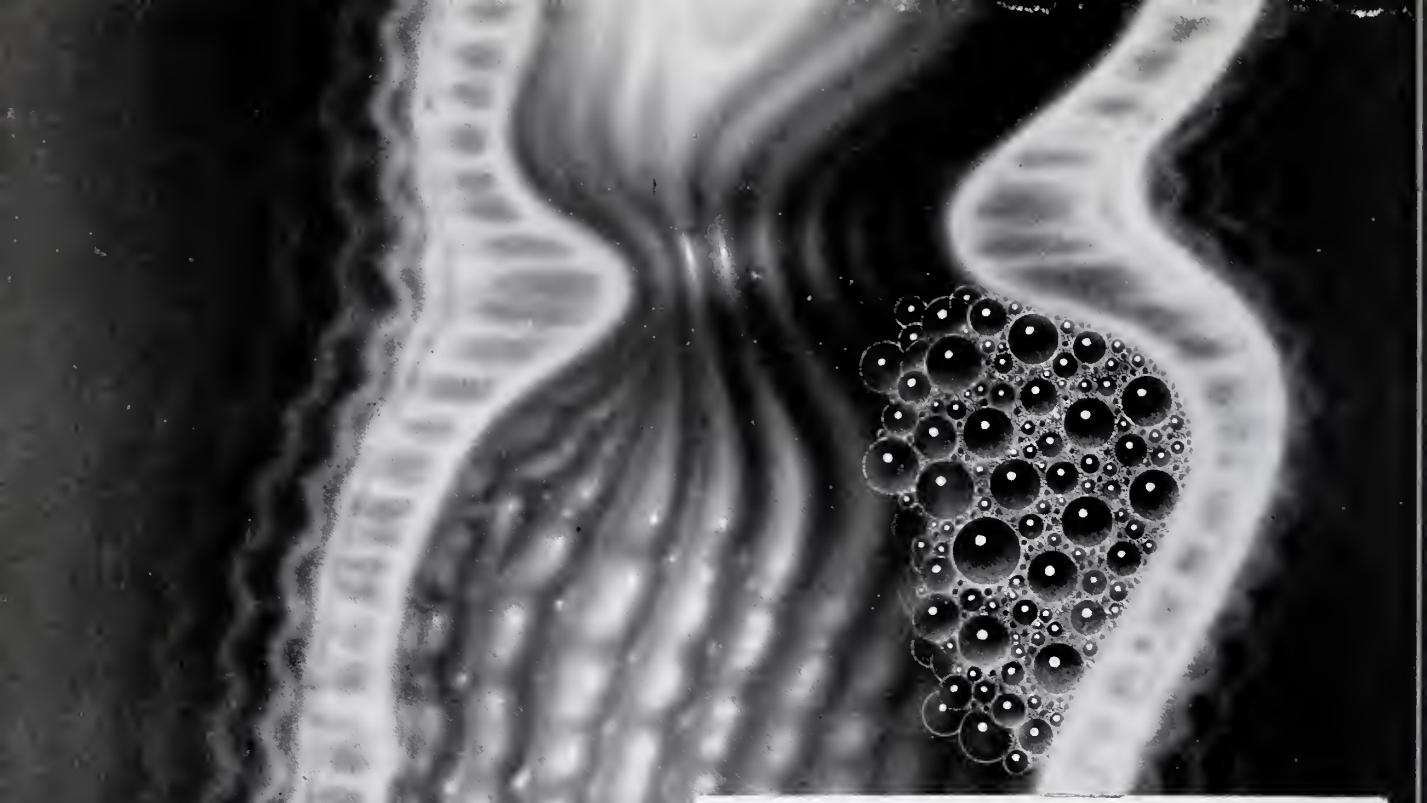
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015



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MEETINGS

Approved by FMA Committee on Continuing Medical Education

OCTOBER

Infection Control Practice—1975, Oct. 2-3, Cedars of Lebanon Health Care Center, Miami. For information: Thelma MacGregor, 1321 N.E. 14 St., Miami 33125.

16th Workshop in Electrocardiography, Oct. 2-6, Tides Hotel, Redington Beach. For information: H. J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33205

Internal Medicine for the Practicing Physician, Oct. 3-4, Perdido Country Club, Pensacola. For information: Richard Lawrence, M.D., Baptist Hospital, 1000 W. Moreno St., Pensacola 32501

Florida Conference: Quality of Life, Oct. 5-7, Americana Hotel, Miami Beach*

Review Course on "Fundamental and Clinical Aspects of Internal Medicine," Oct. 5-18, Key Biscayne Hotel, Key Biscayne (Miami)*

Teaching Conference in Pediatric Radiology, Oct. 8-12, Doral Country Club, Miami*

Arthritis and Orthopaedics, Oct. 17-19, University of Miami, Miami*

Medical Examiners' Commission and the Department of HRS one day conference, Oct. 18, Sheraton Jetport Inn, Orlando. For information: J. E. Fulghum, M.D., P.O. Box 210, Jacksonville 32201

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel & Tennis Club, Key Biscayne*

Orthopaedics and Arthritis, Oct. 17-19, Americana Hotel, Miami Beach*

Teaching Conference in Clinical Pharmacology and Therapeutics, Oct. 22-26, Americana Hotel, Miami Beach*

Peptic Ulcer Disease, Oct. 30, University of South Florida, Tampa+

Florida Society of Internal Medicine and the American College of Physicians Regional Meeting, Oct. 31-Nov. 2, Innisbrook Resort, Tarpon Springs. For information: James A. Winslow Jr., M.D., 1 Davis Blvd., Tampa 33606

NOVEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Nov. 3-8, Jackson Memorial Hospital, Miami*

Hand Surgery, Nov. 7-9, Americana Hotel, Miami*

Preventive Medicine Workshop, Nov. 7-9, Safety Harbor Spa, Safety Harbor, Florida. For information: Center for Human Life Styling, Box 6585, St. Petersburg Beach 33736

New Dimensions in Neurosurgery, Nov. 7-12, Halifax Medical Center, Daytona Beach. For information: Volusia Academy of Medicine, Clyde Morris Blvd., Daytona Beach 32014

First Annual Seminar in Pediatric Anesthesia, Nov. 13-16, Americana Hotel, Miami Beach*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 14-15, Americana Hotel, Bal Harbour*

▶Southern Medical Association, Nov. 16-19, Fontainebleau Hotel, Miami Beach. For information: Mr. Robert F. Butts, 2601 Highland Ave., Birmingham, Alabama 35205

▶American Fracture Association, Nov. 16-20, Americana Hotel, Miami Beach. For information: H. W. Wellmerling, M.D., 600 Livingston Bldg., Bloomington, Illinois 61701

Neurology for Non-Neurologists II, Nov. 19, University of South Florida, Tampa+

The Practitioner Looks at Human Sexuality, Nov. 20-23, Americana Hotel, Miami Beach*

Second Annual Miami International Conference — Progress and Prospects in Health Care Distribution Systems, Nov. 23-27, Americana Hotel, Miami Beach*

IV Management for the Physician Seminar, Nov. 29-30, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

DECEMBER

National Conference on the Role and Training of the General Internist, Dec. 2-5, Americana Hotel, Miami Beach*

Florida Society of Ophthalmology Fall Meeting, Dec. 4-7, Innisbrook Resort and Golf Club, Tarpon Springs. For information: Susan Waits, Suite 346, Barnett Bank Bldg., Tallahassee 32301.

Practical Aspects of Human Sexuality, Dec. 4-7, University of Miami School of Medicine*

The Neonate With Congenital Heart Disease, Dec. 5-6, All Children's Hospital, St. Petersburg+

Intraocular Lenses—Instructional Lens Implant Symposium, Dec. 7-10, Americana Hotel, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Courses in Instruction in Coronary Care for the Practicing Physician, Dec. 8-13, Jackson Memorial Hospital, Miami*

Family Practice—Weekend, Dec. 12-13, International Inn, Tampa+

Nutrition in Serious Illness & Essential Diets, Dec. 12-13, St. Francis Hospital, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Recent Developments in Total Joint Replacement, Dec. 12-14, Miami*

Non-Invasive Methods of Cardiovascular Diagnosis & Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Heart Association of Broward County, 440 N. Andrews Ave., Ft. Lauderdale 33301

Prosthetics & Orthotics, Dec. 15-17, Miami*

▶Medical Staff Law & Bylaws Seminar, Dec. 15-17, Key Biscayne Hotel & Villas, Key Biscayne. For information: Aspen Systems Corp., 11600 Nebel St., Rockville, Md. 20852

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami, Tel. (305) 350-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Hollis G. Boren, M.D., Director, CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

▶ National meetings being held in Florida.

JANUARY

First Annual Postgraduate Seminar, Ultrasound and Nuclear Medicine, "Interrelated Roles in Medical Diagnosis," Jan. 4-7, Sonesta Beach Hotel and Tennis Club, Key Biscayne*

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 5-9, Miami*

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Emergency Cardiac Care: 1976, Jan. 15-18, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33136

Current Concepts in Rheumatology, Jan. 23-24, Sonesta Beach Hotel, Key Biscayne. For information: Roy Altman, M.D., V.A. Hospital, Dept. of Medicine, Miami

Pathology Symposium: Review and Recent Practical Advances, Jan. 20-23, Deauville Hotel, Miami Beach*

Anatomic Pathology Seminar, Jan. 23-26, Deauville Hotel, Miami Beach*

Miami Winter Symposia—Biochemistry, Jan. 1976, Miami*(Dates to be announced)

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Eleventh Annual Postgraduate Course in Internal Medicine, Jan. 26-30, Hotel Fontainebleau*

Course in Hematopathology, Jan. 28-30, VA Hospital, Tampa+

Annual Cardiovascular Seminar, Jan. 30-31, University of South Florida, Tampa+

Twenty-First Central Florida Medical Meeting, Jan. 28-Feb. 1, Orlando. For information: Howard E. Gross, M.D., 15 W. Columbia St., Orlando 32806

FEBRUARY

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Midwinter Seminar in Obstetrics/Gynecology, Feb. 6-8, University of South Florida, Tampa+

Tumors of Infancy and Childhood, Feb. 6-8, All Children's Hospital, St. Petersburg+

Second Annual USF Cancer Seminar, Feb. 14, Ft. Harrison Hotel, Clearwater+

Medical Hypnosis for the Practicing Physician, Feb. 20, Aboard the SS Monarch*

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

Management of Nonsurgical Medical Emergencies, Feb. 25-27, University of South Florida, Tampa+

MARCH

Infant Nutrition, Mar. 4-5, University of South Florida, Tampa+

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Sheraton Four Ambassadors Hotel, Miami*

Annual Suncoast Trauma Seminar, Mar. 18-20, Holiday Inn, Tampa+

Advanced Life Support: The Fourth Annual Postgraduation Seminar in Emergency Medicine, Mar. 19-22, Americana Hotel, Miami Beach. For information: Registrar, 1976 PGS, 1919 Beachway Rd., Jacksonville 32207

Sixth Annual Special Procedures Seminar "Why and How to do Special Procedures," Mar. 21-24, Hyatt House, Miami Beach*

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

Inflammatory Bowel Disease, Mar. 25, University of South Florida, Tampa+

Seventh Annual Topics in Internal Medicine, Mar. 25-27, Gainesville Hilton, Gainesville**

Topics in Adolescent Medicine for the Practicing Physician, Mar. 26, Aboard the SS Monarch*

Diagnosis and Management of Obstructive Airways Disease, Mar. 29-30, University of South Florida, Tampa+

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

APRIL

Spring Symposium in Intensive Care, Apr. 2-5, Diplomat Hotel, Hollywood, Florida*

Office Management of the Infertile Couple, Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608-13th Ave. S., Birmingham, Al 35205

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Asymptomatic Coronary Artery Disease: Early Detection & Management, Apr. 22-23, Hyatt House, Orlando**

Symposium in Cardiovascular Nursing, Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

MAY

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

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Editorial

New Health Legislation Indicates Federal Priorities

FMA Policy on PL 93-641

"The Reference Committee was informed about the recently passed federal law "Health Planning and Resources Development Act of 1974" (PL 93-641). The Committee believes that the impact of this law on the practice of medicine will be of major significance. The Reference Committee recommended that the "Health Planning and Resources Development Act of 1974" be given careful consideration by the Board of Governors and that the Council on Legislation and Regulations develop a plan of action for the Florida Medical Association to deal with this law."—Proceedings of the House of Delegates, April 27, 1975.

A high federal priority of the National Health Planning and Resources Development Act of 1974, which became law on January 4, 1975, is achievement of equal access to quality health care at a reasonable cost. Massive infusion of federal funds into the existing health care system has brought problems, the Congress found, and a comprehensive rational approach has not resulted from responses by both the public and private sectors.

The law has other priorities written into it: provision of primary care services for medically underserved populations; development of multi-institutional systems and of medical group practices; health maintenance organizations and other organized systems for provision of health care; training and increased utilization of physicians' assistants; activities to achieve improvements in the quality of health services; implementation of levels of health care concept on a geographically integrated basis; promotion of activities for prevention of disease, and improved utilization reporting, cost accounting and reimbursement systems.

The Congress stated two conclusions in the Act: The national health policy must address the legitimate needs and concerns of the health care provider as well as the consumer. Large segments of the public lack basic knowledge regarding proper personal health care and methods for effective use of available services.

The purpose of the Act, according to the Congress, is "to facilitate the development of recommendations for a National Health Planning Policy, to augment areawide and state planning for health services, manpower and facilities, and

FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES AND DEPARTMENT OF ADMINISTRATION JOINT RECOMMENDATION FOR PROPOSED HEALTH SERVICE AREA DESIGNATIONS (APRIL 16, 1975)

AREA	SQ. MI.	POPULATION	POPULATION PER SQ. MI.	% CHANGE 1970-73	1980 EST. POPULATION
NO. 1	13,085	748,100	57	8.1	804,100
NO. 2	11,043	504,700	48	18.4	528,700
NO. 3	3,685	663,600	180	5.9	735,200
NO. 4	2,783	1,380,100	496	16.4	1,449,500
NO. 5	4,598	962,100	209	12.8	1,198,300
NO. 6	10,202	709,600	70	19.8	816,700
NO. 7	4,446	553,300	124	16.5	632,400
NO. 8	1,219	738,600	606	19.1	900,000
NO. 9	3,076	1,418,000	461	7.4	1,654,500

☐ STANDARD METROPOLITAN STATISTICAL AREAS

to authorize financial assistance for development of resources to further that policy."

There are two additional major components: Title XV, National Health Planning and Development, and Title XVI, Health Resources Development. The former establishes national guidelines for health planning, provides for establishment of a national council on health planning and development, and establishes regional health systems agencies and state health planning mechanism. The latter provides for state medical facilities plans and grants, and loans and loan guarantees for health facilities. This section of the Act also authorizes project grants to implement plans and priorities developed by the health systems agencies.

Governor Reubin Askew has identified the health service areas, as required, thus initially implementing the new law. There are nine areas which comply with the law's requirements and with existing health services delivery patterns.

With one exception, the service areas coincide with the regions established by the 1975 legislature for the Department of Health and Rehabilitative Services. As a service area Volusia County will continue current health planning with counties in east central Florida, but as part of a region it is aligned with Duval and other northeast Florida counties.

The second action under the Act is development, state review and federal approval of applications for Health Systems Agencies. In six areas the existing health planning agency will prepare the application in the expectation of converting to the Health Systems Agency. The remaining three areas have two health planning agencies and the Tampa Bay area is headquarters for the Florida Regional Medical Program. The agencies will coordinate activities for purposes of completing applications.

Noncontroversial applications should be approved by the state and the U. S. Department of Health, Education, and Welfare by October 1975. Action on those remaining is expected by January 1, 1976. Federal funding of areawide health planning agencies expires on December 31, 1975.

Early in 1976 the State Health Planning and Development Agency will be designated and the State Health Coordinating Council will be established. For practical purposes the agency was established when the Department of Health and Rehabilitative Services Reorganization Act of 1975 combined the Bureaus of Comprehensive Health Planning and Community Medical Facilities Planning. The new organization has been assigned the responsibility.

Council members cannot be appointed, however, until final decisions have been made regarding Health Systems Agencies. The Council, under federal law, must have a minimum of two members from each agency and 60% of total members must be from the agencies. The Council will have a minimum of 18 members from the agencies and 12 statewide representatives. Appointments are to be made by Governor Askew from five nominees submitted by each agency. A majority of members must be consumers. Membership has considerable importance from the standpoint of representation from medicine, health facilities and allied health professions. The net effect is fewer individuals on the Council and fewer positions to represent health care providers.

The impact of the new law upon the private practice of medicine is speculative. It is clear that a national commitment to health planning has been firmly enunciated by the Congress and the Administration. Priorities have been assigned to health care cost containment and to development of coordinated health systems.

The Act states another important principle—federal commitment to implementation through local, regional and state planning. Broad parameters have been established for planning and priority setting but actual decisions and implementation depend upon involvement by health care consumers, health professionals, and elected officials. In the event this proves unworkable, planning may be conducted entirely by government officials and health services delivered increasingly under governmental auspices.

An opportunity exists to avoid such an undesirable result and it includes positive participation by practicing physicians. Each physician should devote time and attention to the new Act and the federal regulations as they are promulgated. Of equal importance, the physician should, wherever possible, actively participate through his county medical society and state association in guiding the development and implementation of the regional and state health plans as required by the new law.

E. Charlton Prather, M.D.
Jacksonville
J. N. Conger
Tallahassee

Mr. Conger is chief of the Bureau of Comprehensive Health Planning for the Florida Department of Health and Rehabilitative Services.

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POSTGRADUATE COURSE

"INTERNAL MEDICINE 1976"

January 25-30, 1976

Fontainebleau Hotel — Miami Beach, Florida

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Program Coordinator:
Jose S. Bocles, M.D.

THE OBJECT OF THIS COURSE, THE ELEVENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS. EACH SUBSPECIALTY WILL BE INTRODUCED BY A STATE OF THE ART LECTURE GIVEN BY A DISTINGUISHED AUTHORITY.

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J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia, Cardiovascular Diseases.

Donald J. Massaro, M.D., Professor of Medicine, The George Washington University School of Medicine, Washington, D.C., Pulmonary Diseases.

Louis Weinstein, Ph.D., M.D., Visiting Professor of Medicine, Harvard Medical School, Physician, Peter Bent Brigham Hospital, Boston, Massachusetts, Infectious Diseases.

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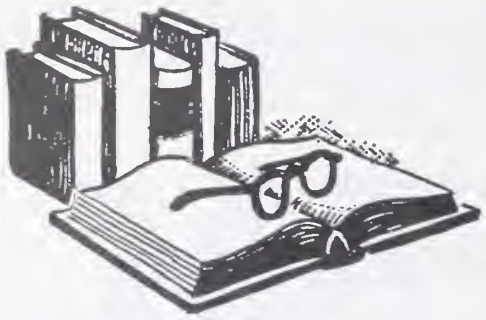

Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

If You Meet The Buddha On The Road, Kill Him! by Sheldon B. Kopp. 182 Pages. Price $6.95. Ben Lomond, California, Science and Behavior Books, Inc., 1972.

". . . a patient . . . more often than not . . . really wants . . . to remain the same and to get the therapist to make him feel better. . . . He prefers the security of known misery to the misery of unfamiliar insecurity." This statement touched me in my struggle to meet patients as one human being to another. It strikes me that physicians are, or should be, in the process of change—promoting growth-producing habits instead of self-defeating ones. In brief chapters, with poetic language, Sheldon Kopp gives his insights about producing beneficial change and growth. In the manner of Sidney Jourard, Kopp feels that disclosing himself is important to getting the patient better. "A man not only needs someone to hear his tale, but someone to care as well." "When I work with a patient, not only will I be hearing his tale, but I shall be telling him mine as well."

Pithy expressions sprinkle the brief chapters. ". . . a spouse often complains bitterly about having to live with a mate who is acting just the way that he (or she) found most attractive during courtship."

"What people look for in marriage, at least in part, is the other half of themselves." "Sex is an arena within which other kinds of problems get played out."

Two chapters which struck me forcefully was his own description of the folly of his youth—the naive thoughts and experimentation with marijuana. The other was his brief chapter on his feelings surrounding his operation for what seems to be, from his description, an acoustic neuroma. Additional pithy sayings come from the list which is important to him; "Everyone lies, cheats, pretends (yes, you too, and most certainly I myself)." "Love is not enough, but it sure helps."

"Learn to forgive yourself, again, and again, and again, and again. . . ."

If you would learn the significance of the title, you must read the book.

F.N.V.

Pancreas by Larry C. Carey, M.D. 456 Pages. Price $39.75. St. Louis, The C. V. Mosby Company, 1973.

"Written to provide, in single volume, current information concerning diseases of the pancreas," says author Larry C. Carey. Twenty chapters written by outstanding experts in the field cover normal and abnormal anatomy, pancreatitis, neoplasm, and trauma. There is even a chapter which discusses the recent unsuccessful experience at pancreatic transplantation.

Well edited and clearly written, this book provides a basic reference on pancreatic disease.

F.N.V.

Clinical Perinatology edited by Silvio Aladjem, M.D. and Audrey K. Brown, M.D. 492 Pages. 135 Illustrations. Price $41.50. St. Louis, The C. V. Mosby Company, 1974.

I must confess I was not sure what perinatology meant; even less knowledgeable about Clinical Perinatology; however, a group of obstetricians and pediatricians together with an attorney and pathologist have written this book and have defined and described in detail this "new" branch of medicine. These authors live and work in Finland, Japan, Britain, Spain and France as well as the United States. They regard perinatology as the study of the disorders of the embryo, fetus and newborn. They discuss, in this context, maternal disease, intrauterine infections, genetic problems and placental abnormalities. Also there are discriptions of modern fetal monitoring, amniocentesis, labor stress, and even predictive indices of neonatal morbidity and mortality.

The book is excellent. For us pathologists, the chapter on fetal and newborn autopsies, often difficult and unrewarding, is meticulously handled and will be a great reference source. Of course, the potential troubles for the mother and unborn child are legion. Many of these are dissected with clarity and detail, i.e., don't rupture membranes unless you have to.

Even if you are up-to-date, you will be amazed at the number and variety of studies being carried out to "improve fetal and neonatal survival and overall quality of life."

Courtlandt D. Berry, M.D.
Ocala

Pancreatitis by Earle Gambill, M.D. 302 pages. 132 illustrations. Price $28.50. St. Louis, C. V. Mosby Company, 1973.

This volume by one of the authorities in the field, with contributions from his associates at the Mayo Clinic, assembles in one volume the basic information on pancreatitis. The chapters of most interest to me were the historical developments in the evaluation of the pancreas and the chapter on exocrine pancreatic function tests.

This volume will be of little interest to the practicing physician. For example, the chapter on medical treatment of pancreatitis is only five pages. This volume will be of use to the student and house officer who desires to review the pertinent aspects of pancreatitis within the pages of one volume.

F.N.V.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1957.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

How to Beat Fatigue by Linda Pembrook. 223 Pages. Price $6.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975

Problem-Directed and Medical Information Systems edited by Marshall F. Driggs, M.D. 241 Pages. Illustrated. Price $15.45. New York, Intercontinental Medical Book Corporation, 1973.

Review of Physiological Chemistry, 15th Edition by Harold A. Harper, Ph.D. 570 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1975.

Handbook of Psychiatry, edited by Philip Solomon, M.D. and Vernon D. Patch, M.D. 705 Pages. Price $8.00. Los Altos, California, Lange Medical Publications, 1974.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

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3. Hyperlipidemia
4. Infectious Diseases in Children
5. Management of Adolescent Problems
6. Newer Antibiotics
7. Newer Concepts of Family Planning
8. Office Management of Sexual Difficulties
9. Peripheral Vascular Disease—Diagnosis and Treatment
10. Pulmonary Function Tests and Blood Gases

Monday-Wednesday, Dec. 1-3 (Numbers 1-10)
1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Monday-Wednesday, Dec. 1-3/10:30 AM-Noon (4½ hour, 3-day course: $45)
11. Acid-Base, Fluid and Electrolyte Balance
12. Advanced Electrocardiography
13. Critical Patients—Critical Decisions
14. Normal and Abnormal Uterine Bleeding
15. Office Management of Anorectal Disorders
16. Office Practice of Gynecology
17. Physicians' Marriages
18. Special Problems of Child Abuse
19. Surgical Lesions of the Intestines—Diagnosis and Treatment
20. Treatment of Common Pediatric Allergies

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Thursday-Friday, Dec. 4-5/7:30-10:30 AM (6 hours for total course; 3 hours on Thursday, 3 hours on Friday: $60)
21. Acid-Base, Fluid and Electrolyte Balance (repeat)
22. Basic Electrocardiography
23. Birth Defects and Clinical Genetics
24. Dermatology for Non-Dermatologists (repeat)
25. Fetal Monitoring
26. Ophthalmoscopy for the Non-Ophthalmologist
27. Pediatric Cardiology
28. Pitfalls of Emergency Room X-Rays
29. Office Endocrinology
30. Immunology—1976
31. The Uterine Pap Smear

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33. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 2) _____

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34. Advanced Life Support—Cardiopulmonary Resuscitation. (Prerequisite: Basic Life Support Course) (Dec. 3-5) _____

Courses of the AMA Committee on the Medical Aspects of Sports (Each a 3-hour course: $30)
Monday, Dec. 1/7:30-9:00 AM & 10:30-Noon
35. The Physical Exam _____

Tuesday, Dec. 2/7:30-9:00 AM & 10:30-Noon
36. The Oriental Arts (Karate, Judo, Yoga) _____

Wednesday, Dec. 3/7:30-9:00 AM & 10:30-Noon
37. Emergency Care on the Field _____

Thursday, Dec. 4/7:30-10:30 AM
38. Wrestling _____
39. Aquatic Sports _____

Friday, Dec. 5/7:30-10:30 AM
40. Rehabilitation _____

Tuesday-Wednesday, Dec. 2-3/7:30-10:30 AM (6 hours for total course; 3 hours on Tuesday, 3 hours on Wednesday: $60)
41. Writing for Scientific Journals _____

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Tuesday, December 2 (12:15-1:45 PM) • Topic—Ancient Polynesian Medicine _____
Thursday, December 4 (12:15-1:45 PM) • Topic—Dehli Belly, Gyppy-Tummy, and Other Diseases of Travelers _____

General Registration

_____ Non-member physicians: $35
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_____ Foreign M.D.'s: no fee
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_____ Medical students, interns and residents: no fee

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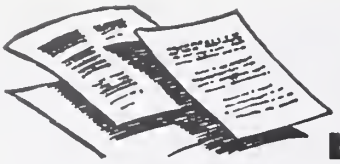

Letters

To the Editor: As the physicians of Florida know, we are working diligently to reduce the number and amount of settlement of malpractice claims in Florida.

I have attended many meetings regarding the subject of malpractice and respectfully suggest your consideration of the following suggestion:

> "Except for emergency cases where the patient is either unconscious or unable to sign a consent form or if a close relative is not available, all consent forms for both diagnostic and surgical procedures (medical and surgical) be signed by the patient in the presence of the physician in charge whenever possible."

There have been cases reported in the literature where nurses attempt to have a sick or sleepy patient sign a consent form in the evening prior to the day that the procedure will be performed and later, during the trial for malpractice, the patient states under oath that he or she cannot remember giving permission, etc.

David J. Lehman, M.D.
State Representative
District 97
Hollywood

To the Editor: Sometimes free consultations out of the field of your specialty can lead you into difficulty.

Recently I instructed a 79-year-old female relative of mine who had strained her lower back to wrap the aching area with plastic material that dry cleaning establishments use to cover hanging garments for delivery. The material holds heat in the normal body and warms the area. However, at 9:00 p.m. she applied Ben-Gay Lotion to her lumbar region before employing the plastic material. She repeated the Ben-Gay and plastic material at 2:00 a.m. At 8:00 a.m., (11 hours after the first application), she removed the wrapping and discovered the skin to be red and painful. Within two days she developed vesicles up to 2 cm. in diameter which ultimately drained. It took about four weeks for the area to heal, requiring topical antibiotics and Telfa dressings.

Ben-Gay Lotion, containing methyl salicylate and menthol, is recommended by its manufacturer for "arthritis, rheumatism, strains, stiff neck, sore and aching and tight muscles, and chest cold discomfort." It might be well to advise people using Ben-Gay not to cover the treated area with wrappings, especially plastic material.

Frank J. Beasley, M.D.
Ft. Lauderdale

To the Editor: Tuberculosis continues to be a major concern in Florida. Reported cases this year showed an increase of 146 during the first six months when compared with 1974 figures. The only hope for reducing this high figure is through increased case finding.

All physicians in private practice are urged to report cases of active tuberculosis. And, what is equally important, make sure that all contacts are adequately investigated with tuberculin testing and x-rays of the chest as indicated.

The latest recommendations regarding treatment of active cases and prophylactic treatment for high risk contacts are available through the Bureau of Tuberculosis Control, Division of Health, P.O. Box 210, Jacksonville, Florida 32201.

W. Dean Steward, M.D., Administrator
Section of Community Programs
Bureau of Tuberculosis Control
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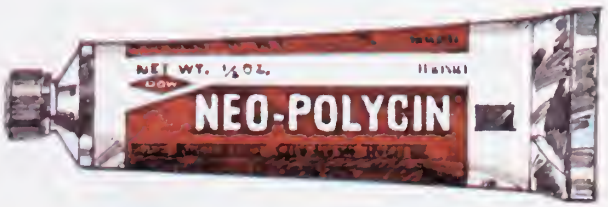

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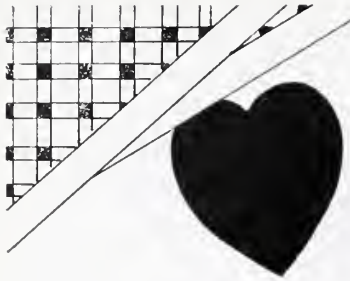

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CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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desiccated thyroid

consider the differences...

Desiccated animal gland thyroid products can vary in potency from batch to batch.

Because iodine content rather than biological assay is used to measure the standard of many desiccated thyroid products, biologic activity can vary from batch to batch. Even when biologic assay is employed, biologic activity can only be approximated.

1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

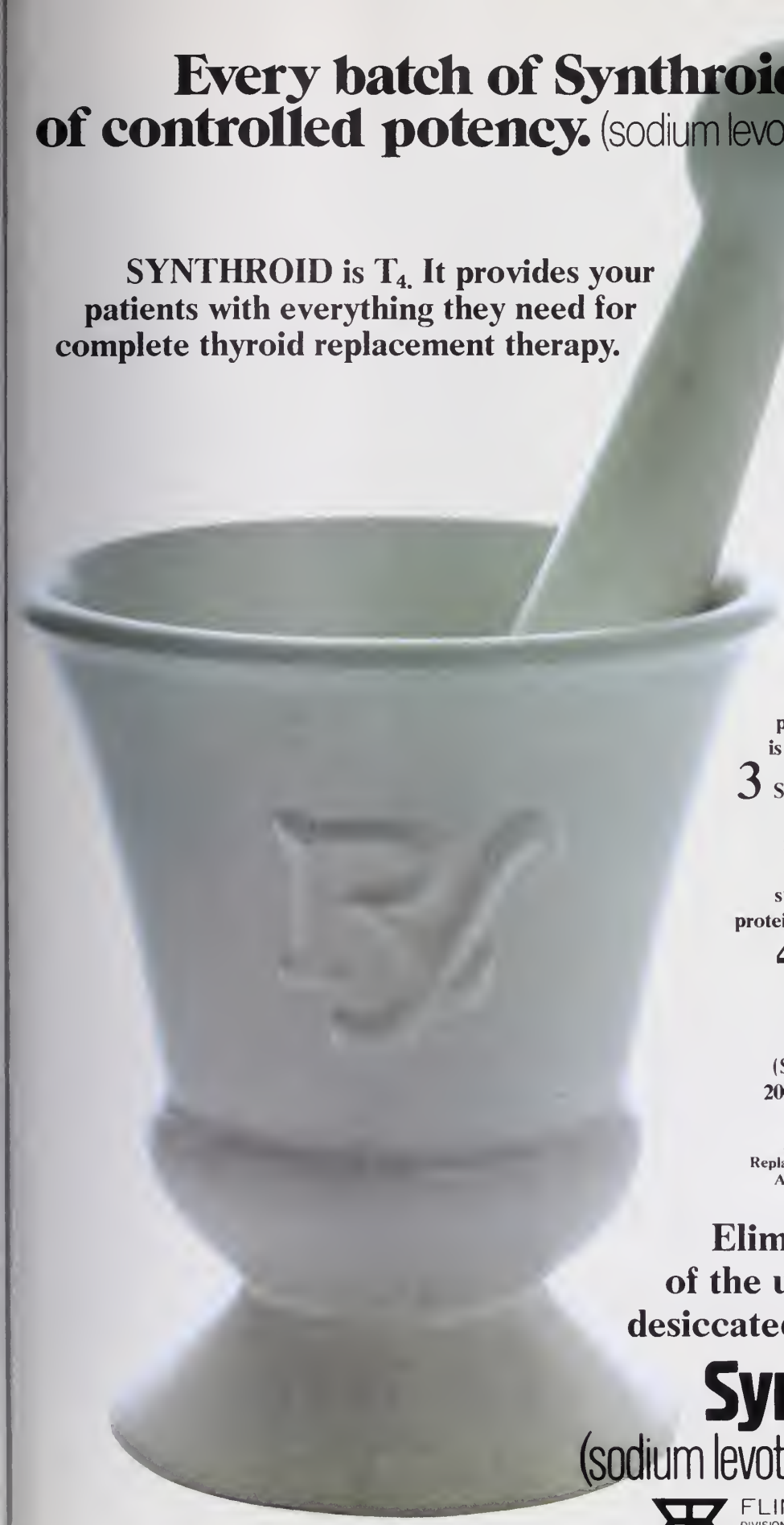
2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

Every batch of Synthroid® T_4 is of controlled potency. (sodium levothyroxine, U.S.P.) FLINT



SYNTHROID is T_4. It provides your patients with everything they need for complete thyroid replacement therapy.

1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

Synthroid®

(sodium levothyroxine, U.S.P.) FLINT

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DIVISION OF TRAVENOL LABORATORIES, INC
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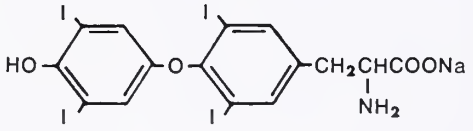
See reverse side for full prescribing information.

Synthroid®
(sodium levothyroxine, U.S.P.*) FLINT

Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets**, taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets**, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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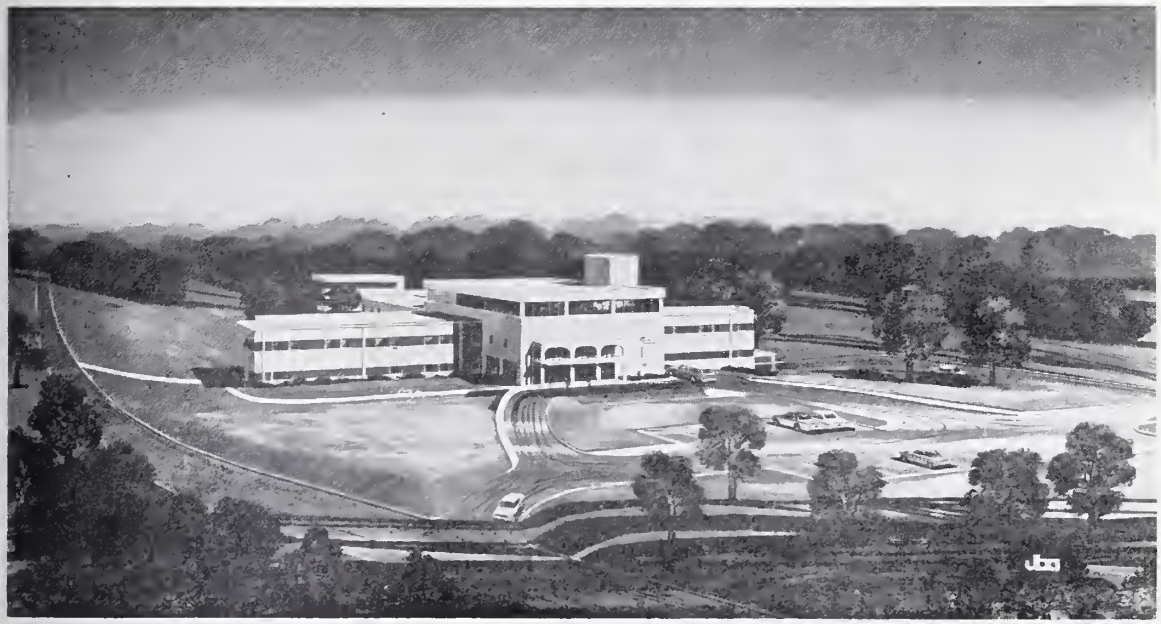
*U.S. Pat. 2,889,363



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NOTE: IN MAKING THIS APPLICATION FOR CREDIT, IT IS UNDERSTOOD THAT AN INVESTIGATIVE REPORT MAY BE MADE WHEREBY INFORMATION IS OBTAINED THROUGH PERSONAL INTERVIEWS WITH THIRD PARTIES. THIS INQUIRY INCLUDES INFORMATION AS TO YOUR CHARACTER, GENERAL REPUTATION, PERSONAL CHARACTERISTICS, AND MODE OF LIVING, WHICHEVER MAY BE APPLICABLE. YOU HAVE THE RIGHT TO MAKE A WRITTEN REQUEST WITHIN A REASONABLE PERIOD OF TIME FOR A COMPLETE AND ACCURATE DISCLOSURE OF THE NATURE AND SCOPE OF THE INVESTIGATION.

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Florida Organizations of Medical Interest Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association	Vernon B. Astler, Boynton Bch.	James W. Walker, Jacksonville	May 5-9, 1976, Hollywood
Florida Specialty Societies			
Allergy Society	Gerard F. Carter, Miami	Rodger J. Zwemer, Vero Beach	
Anesthesiologists, Soc. of	Arthur J. Stevenson, Tampa	John C. Kruse, Jacksonville	
Chest Phys., Fla. Chap. Am. Coll.	Edmund C. Roll, Orlando	Roberto Llamas, Miami Bch.	
Dermatology, Society of	Hillard J. Halpryn, Hialeah	Daniel Roberts, Rockledge	
Emergency Phys. Fla. Chap.	J. Clifford Findeiss, Miami	(no secretary)	
Endocrine Society	Eugene T. Davidson, Lakeland	George Heffner, Ft. Lauderdale	
Family Physicians	Donald G. Nikolaus, Dunedin	Charles A. Dunn, Miami	
Gastroenterologic Society	James L. Borland Jr., J'ville	John J. Kennedy, Orlando	
Internal Medicine	C. Russell Smith Jr., Lakeland	Rose E. London, Miami Bch.	
Nephrology Society	John E. Cunio, Miami	William W. Anderson, Miami	
Neurology Society	Jacob Green, Jacksonville	Richard L. Parker Jr., Winter Pk.	
Neurosurgical Society	Robert Tolmach, Miami Shores	Hubert Aronson, Miami	
Nuclear Physicians	August Miale Jr., Miami	Dorothy G. Lloyd, Orlando	
Obstetric & Gynecologic Soc.	Henry L. Wright, Boca Grande	George N. Lewis, Tallahassee	
Ophthalmology Society	John W. Glotfelty, Lakeland	Reginald J. Stambaugh, W. Palm Bch.	
Orthopedic Society	Richard D. Hoover, W. Palm Bch.	James F. Richards Jr., Orlando	
Otolaryngology Society	Julian H. Groff, N. Miami Bch.	Hueston C. King, Miami	
Pathologists Society	Anthony R. Clerch, Miami	Pablo Enriquez, Gainesville	
Pediatric Cardiologists	Robert H. Miller, J'ville	Ira H. Gessner, Gainesville	
Pediatric Surgeons	H. Warner Webb, Jacksonville	James L. Talbert, Gainesville	
Pediatric Society, Fla. Chap. Am. Acad. of Pediatrics	James M. San, Tampa	Stephen P. Gyland, Jacksonville	
Phys. Medicine & Rehabilitation Society	Justine L. Vaughen, Gainesville	Charles J. Kurth, Orlando	
Physicians, Am. Coll. of	Leighton E. Cluff, Gainesville	(no secretary)	
Plastic & Recon. Surgery	Bernard L. Kaye, Jacksonville	William F. Hogan, Ft. Lauderdale	
Preventive Medicine	Rafael A. Penalver, Miami	James T. Howell, Palm Sprgs.	
Proctologic Society	Manuel Carbonell, Miami	Walter W. Hamilton, St. Pete	
Psychiatric Association	Daniel S. Hellman, St. Pete	Richard E. Gordon, Gainesville	
Radiological Society	Paul A. Mori, Jacksonville	Alfred Schick, Clearwater	
Rheumatology Society	Jaques Caldwell, Gainesville	Louis R. Ricca, St. Petersburg	
Surgeons, Fla. Chap. Am. Coll.	George L. Irvin III, Miami	Frank A. Mergen Jr., Miami	
Surgeons, Gen. Fla. Assn.	George H. McSwain, Daytona Bch.	Robert H. Hux, Leesburg	
Surgeons, Surg. Div. Int'l. Coll.	Julian A. Rickles, Miami Beach	(no secretary)	
Thoracic Surgeons	Nelson H. Kraeft, Tallahassee	Robert B. Trumbo, Orlando	
Urological Society	John R. Browning, Jacksonville	Raymond J. Fitzpatrick, Gainesville	
FLORIDA DIVISION:			
American Cancer Society	Martin Gould, Vero Beach	Mrs. Charles Prescott, Tallahassee	Orlando, November 14, 1975
Arthritis Foundation	Sam P. Lewis, Hollywood	Ted K. Grahn, Holmes Beach	Palm Beach, May 23-24, 1976
Blue Shield of Florida, Inc.	Joseph G. Matthews, Orlando	John S. Slye, Jacksonville	Hollywood, May 5-9, 1976
Board of Medical Examiners	M. R. Pope, Plant City	Benjamin M. Cole, Orlando	Tampa, January 11-12, 1976
Crippled Children & Adults	J. Ward Dougherty, Lutz	Stephen Bullock, Lynn Haven	Sarasota, October 24-26, 1975
Epilepsy Foundation	Mrs. Dolores Benedict, Lake Worth	Mrs. Dorothy Reese, Tampa	(Unknown)
Florida Heart Association	William M. Madison, Jr., Jacksonville	S. Lee Crouch, Hallandale	Orlando, May 28-30, 1976
Florida Kidney Foundation	Jay M. Whitworth, Jacksonville	Barbara W. Burgess, Jacksonville	(Unknown)
Florida Lung Association	Mrs. Jeanne Malchon, St. Petersburg	Howard M. DuBose, Lakeland	Tampa, April 23-24, 1976
Florida Physicians Association, Inc.	James T. Cook, Marianna	Paul C. Harding, Orlando	Hollywood, May 5-9, 1976
Mental Health Association	Mrs. Jan E. McGee, Gainesville	Mrs. Wilbur Donner, Fort Pierce	Miami Beach, October 24-26, 1975
Prevention of Blindness	Robert W. Andrew, Tampa	Mrs. R. J. Willaford, Tampa	Tampa, January 1976
Retarded Children	Leo Plotkin, Miami	Mrs. Dolores Cole, Satellite Beach	Daytona Beach, Sept. 10-13, 1975
United Cerebral Palsy	Wendell Agee, Sanford	Russell Barakat, Fort Lauderdale	Tampa (Date has not yet been set)
Woman's Auxiliary to FMA	Mrs. C. Brooks Henderson, Ocala	Mrs. William Harrison, Daytona Beach	Hollywood, May 5-9, 1976

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

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OUR PRESENT DEPARTMENT OF PSYCHIATRY is a three man department. We wish to double the size of this over the next three to four years. All candidates must be Board eligible. General psychiatrists or someone with subspecialty interests would be acceptable. Our department is a member of a multispecialty group located in Pensacola, Florida. Inquiries should be sent to W. M. C. Wilhoit, M D., Chairman, Department of Psychiatry, The Medical Center Clinic, 1750 N. Palafox St., Pensacola, Florida 32501.

WANTED: GENERAL SURGEON, Board certified; preferably with Gyn training and/or experience; under age 50. Present surgeon disabled, possibly permanently. Opportunity to take over 25 years old surgical practice in 6-9 months. Call (305) 293-9150 or write Alex P. Maybarduk, M.D., 710 East Colonial Drive, Orlando, Florida 32803.

TWO ANESTHESIOLOGISTS NEEDED: Growing multispecialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northwest Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPAEDIC SURGEON—FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

Miscellaneous

SUNLAND CENTER AT TALLAHASSEE, a state institution for the mentally retarded is seeking licensed M.D. for a Career Service position. Address inquiries to: 2323 Phillips Road, Tallahassee, Florida 32304 or phone (904) 488-1524.

VP/MEDICAL DIRECTOR wanted for leading prepayment health insurance firm. Seek experienced practitioner, Florida license required, member (or eligible for membership) in state and county medical societies. Administrative skills and ability to work with other corporate officers essential; knowledge of private and government health insurance programs and concepts is important. Successful candidate will contribute significantly to the organization through constant awareness of current medical practice; ability to work with full and part time physicians and with nonmedical personnel. Excellent salary and benefits. An equal opportunity employer (M/F). Submit resume to Vice President of Human Resources, C-696, P.O. Box 2411, Jacksonville, Florida 32203.

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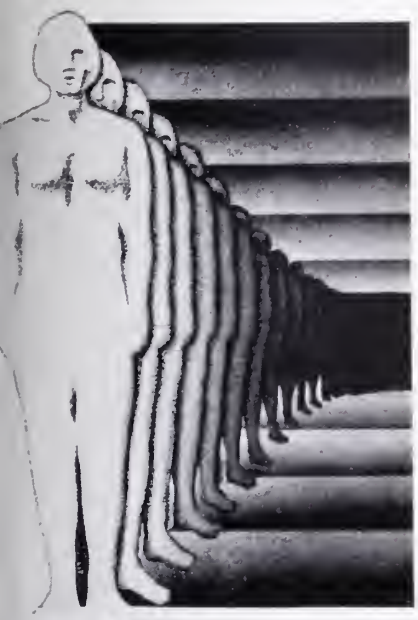

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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LIBRIUM®
chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

IN PAINFUL ACUTE CYSTITIS*

*nonobstructed; due to susceptible organisms

RELIEVE THE PAIN

WHILE YOU ELIMINATE THE PATHOGENS.

FOR THE PAIN

☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, oid

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eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

5

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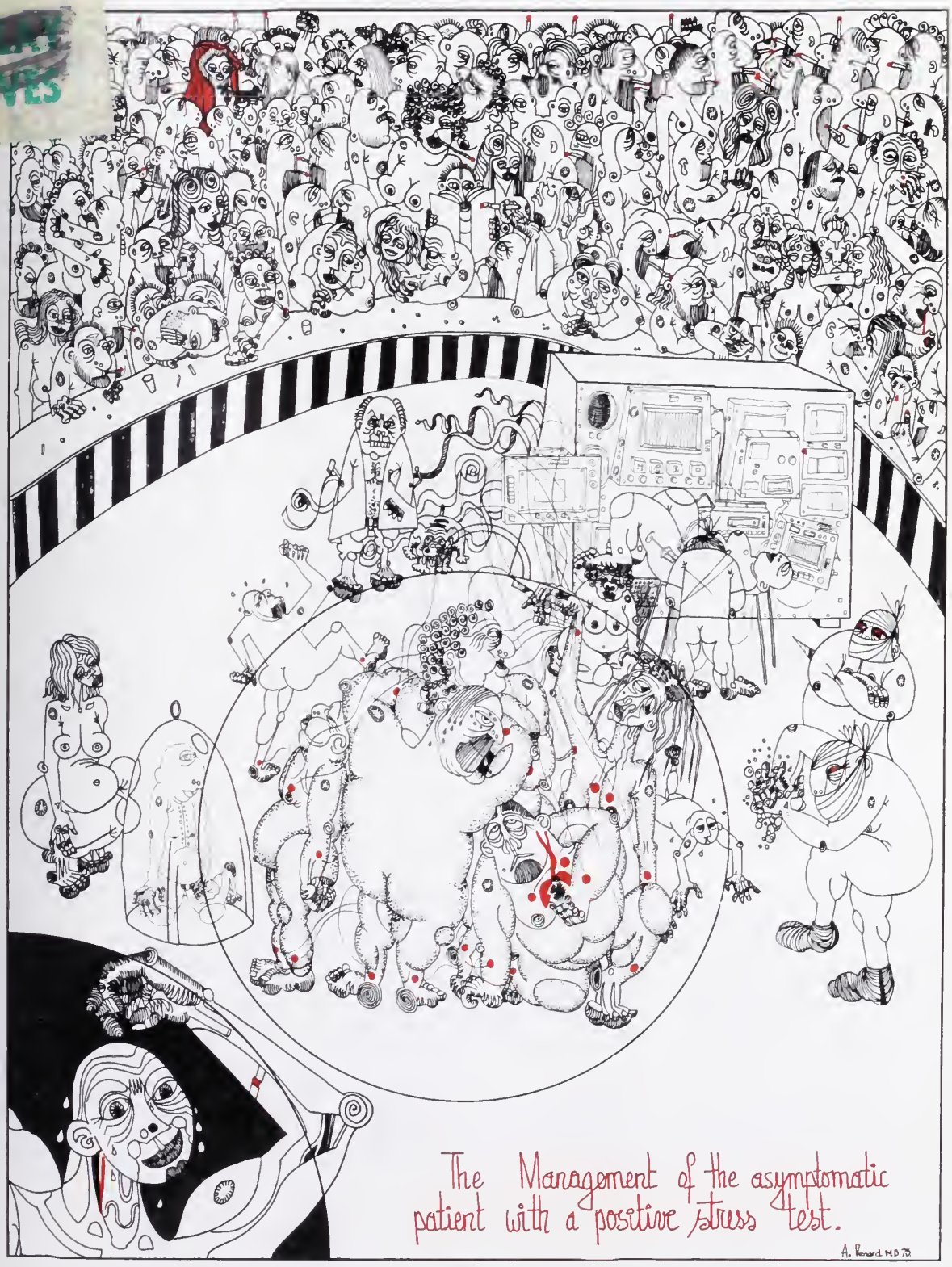
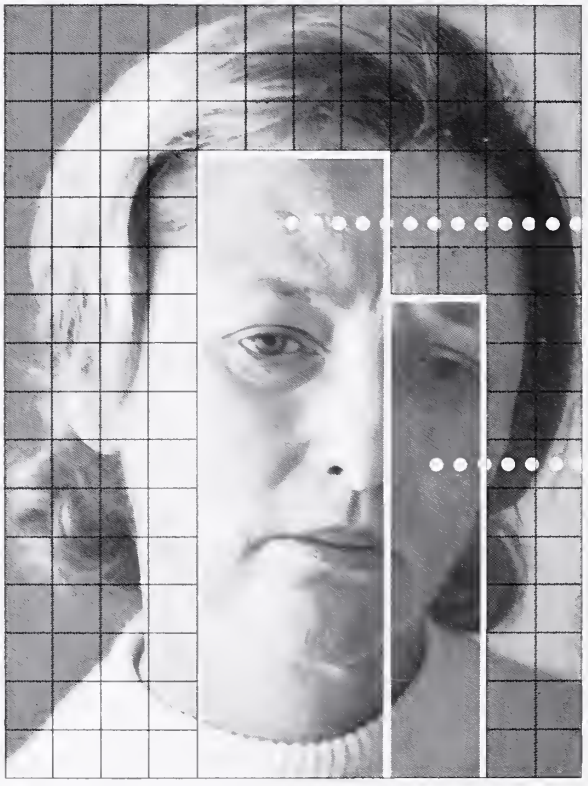


November is Mental Retardation Month (See Pages 36-41)

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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November Cover—The cover, symbolizing stress and highlighting the lead article entitled "Management of the Asymptomatic Patient With a Positive Stress Test," by C. Richard Conti, M.D., is by Andre Renard, M.D., Jacksonville. Dr. Renard is from Belgium, doing a residency in Plastic Surgery. We are very grateful to Dr. Renard for sharing one of his fine talents with us.

President's Page

Unity

In reviewing some classics recently, I was impressed by the contemporary value of one principle outlined therein. This principle was, to factionate a powerful enemy or adversary in order to conquer him. If one accepts the validity of this principle, the obvious corollary is that *unity is essential* in order to prevail over the adversary.

During the current professional liability crisis we must guard against fragmenting FMA from within. It is predictable that a few members of any organization will be dissatisfied much of the time and also that many of the other members will be dissatisfied on rare occasions. The *Sine Qua Non* for success in the professional liability crisis is a broad base of our membership pulling together. Of late, a few of our well-meaning members have carried the democratic privilege of self-criticism of the organization beyond the bounds that common sense would dictate. Often these dissidents utter their criticism in an open meeting or forum before a legislative committee without having followed the proper channels. Your leaders in FMA have labored long and hard to provide a satisfactory self insurance program to the membership when no other suitable underwriter could be found following a thorough search of the marketplace.

While we are cognizant of the fact that further legislative relief must be forthcoming from Tallahassee to allow the successful operation of this program, we must realize the legislative wheels sometimes turn slowly and one cannot expect to accomplish all in one giant step. In fact, in those states where the more militant and forceful approach has been attempted, the result has often been an unfavorable over-reaction on the part of the state legislature. Without last year's professional liability package, we could not even have formed our self insurance trust and we physicians would have been left with the alternative of enrolling in the Joint Underwriting Association (J.U.A.) at two and one-half to three times the published rates offered in September under our self insurance program.

Your officials are diligently striving to affect further legislative change to assure the success of this program and the ongoing delivery of health care to the citizens of Florida at a realistic price. Vocal dissidents among us who choose to appear as self appointed spokesmen before legislative committees can only serve to confuse the issues and thwart our objectives. Unfortunately, these men are unknowingly in violation of the principle previously referred to and in fact are our strongest adversaries. These individuals should voice their constructive criticisms within the proper channels of the Association rather than offering untimely bursts of emotionalism which serve to disrupt or confuse properly constituted meetings. The proper chain of command should begin with the county legislative committee. From there to the county membership for approval or disapproval and then to the state legislative committee for similar action. The state committee's recommendation must then be sanctioned by the state membership through its House of Delegates and Board of Governors. The policies promulgated through this process should be finally presented to the state legislators in a unified way by properly constituted spokesmen of our organization.

I, therefore, urge each of our members and officers to follow these guidelines and please insist that your colleagues do likewise. For only with unity and total devotion to cause can an organized minority prevail.

Vernon B. Astler

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estroger Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estroger complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contain natural estrogens exclusively and al meets all U.S.P. specifications for conjugated estrogens. Assurance o quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

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AYERST LABORATORIES
New York, N.Y. 10017

MEETINGS

Approved by FMA Committee on Continuing Medical Education

NOVEMBER

Courses in Instruction in Coronary Care for the Practicing Physician, Nov. 3-8, Jackson Memorial Hospital, Miami*

Hand Surgery, Nov. 7-9, Americana Hotel, Miami*

Preventive Medicine Workshop, Nov. 7-9, Safety Harbor Spa, Safety Harbor, Florida. For information: Center for Human Life Styling, Box 6585, St. Petersburg Beach 33736

New Dimensions in Neurosurgery, Nov. 7-12, Halifax Medical Center, Daytona Beach. For information: Volusia Academy of Medicine, Clyde Morris Blvd., Daytona Beach 32014

First Annual Seminar in Pediatric Anesthesia, Nov. 13-16, Americana Hotel, Miami Beach*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 14-15, Americana Hotel, Bal Harbour*

▶Southern Medical Association, Nov. 16-19, Fontainebleau Hotel, Miami Beach. For information: Mr. Robert F. Butts, 2601 Highland Ave., Birmingham, Alabama 35205

▶American Fracture Association, Nov. 16-20, Americana Hotel, Miami Beach. For information: H. W. Wellmerling, M.D., 600 Livingston Bldg., Bloomington, Illinois 61701

Neurology for Non-Neurologists II, Nov. 19, University of South Florida, Tampa+

The Practitioner Looks at Human Sexuality, Nov. 20-23, Americana Hotel, Miami Beach*

Cancer Conference: Diagnosis and Management of Colon Cancer, Nov. 21, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Second Workshop in Use of Staplers in Surgery, Nov. 21-22, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Second Annual Miami International Conference — Progress and Prospects in Health Care Distribution Systems, Nov. 23-27, Americana Hotel, Miami Beach*

IV Management for the Physician Seminar, Nov. 29-30, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

DECEMBER

National Conference on the Role and Training of the General Internist, Dec. 2-5, Americana Hotel, Miami Beach*

Florida Society of Ophthalmology Fall Meeting, Dec. 4-7, Innisbrook Resort and Golf Club, Tarpon Springs. For information: Susan Waits, Suite 346, Barnett Bank Bldg., Tallahassee 32301.

Practical Aspects of Human Sexuality, Dec. 4-7, University of Miami School of Medicine*

The Neonate With Congenital Heart Disease, Dec. 5-6, All Children's Hospital, St. Petersburg+

Intraocular Lenses—Instructional Lens Implant Symposium, Dec. 7-10, Americana Hotel, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Courses in Instruction in Coronary Care for the Practicing Physician, Dec. 8-13, Jackson Memorial Hospital, Miami*

Family Practice—Weekend, Dec. 12-13, International Inn, Tampa+

Nutrition in Serious Illness & Essential Diets, Dec. 12-13, St. Francis Hospital, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Recent Developments in Total Joint Replacement, Dec. 12-14, Miami*

"Severe Facial Injuries," Annual Meeting, Plastic & Maxillofacial Surg. Society, Dec. 12-14, Skycenter Inn, Jacksonville Airport, Jacksonville

Non-Invasive Methods of Cardiovascular Diagnosis & Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Heart Association of Broward County, 440 N. Andrews Ave., Ft. Lauderdale 33301

Prosthetics & Orthotics, Dec. 15-17, Miami*

▶Medical Staff Law & Bylaws Seminar, Dec. 15-17, Key Biscayne Hotel & Villas, Key Biscayne. For information: Aspen Systems Corp., 11600 Nebel St., Rockville, Md. 20852

Cancer Conference: Management of Skin Neoplasia, Dec. 19, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

JANUARY

First Annual Postgraduate Seminar, Ultrasound and Nuclear Medicine, "Interrelated Roles in Medical Diagnosis," Jan. 4-7, Sonesta Beach Hotel and Tennis Club, Key Biscayne*

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 6-9, Key Biscayne Hotel, Key Biscyane*

13th Annual Postgraduate Seminar in Anesthesiology, Jan. 9-11, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Shock, Jan. 9-14, Halifax Hospital Medical Center, Daytona Beach. For information: Volusia Academy of Medicine, Clyde Morris Blvd., Daytona Beach 32014

The Role of the Medical Director in the Skilled Nursing Facility, Jan. 10-11, International Hotel, Tampa. For information: Philip H. Gilbert, Dir. Foundation Dept., Florida Medical Association, P. O. Box 2411, Jacksonville 32203.

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

▶National meetings being held in Florida.

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Vitreo-Retinal Symposium, Jan. 12-15, Key Biscayne Hotel, Key Biscayne*

Miami Winter Symposia, Jan. 12-16, Sheraton Four Ambassadors Hotel, Miami*

10th Annual Postgraduate Seminar in Surgery, Jan. 14-17, Eden Roc Hotel, Miami Beach*

Oral Surgery Seminar, Jan. 15-17, Fontainebleau Hotel, Miami Beach*

Emergency Cardiac Care: 1976, Jan. 15-18, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33136

Review & Recent Practical Advances in Pathology, Jan. 20-23, Deauville Hotel, Miami Beach*

Infectious Diseases: Treatment and Prevention 1976, Jan. 21-23, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Clinical Topics in Child Neurology, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Pediatric & Adult Urology Postgraduate Seminar, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Cancer Conference: Carcinoma of the Kidney and Renal Pelvis, Jan. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Current Concepts in Rheumatology, Jan. 23-24, Sonesta Beach Hotel, Key Biscayne. For information: Roy Altman, M.D., V.A. Hospital, Dept. of Medicine, Miami

Anatomic Pathology Workshop, Jan. 23-25, Deauville Hotel, Miami Beach*

Continuing Education in Pediatrics, Jan. 26-29, Diplomat Hotel, Hollywood, Florida. For information: Variety Childrens Hospital, 6125 S.W. 31st St., Miami 33155

11th Annual Postgraduate Course in Internal Medicine 1976, Jan. 26-30, Fontainebleau Hotel, Miami Beach*

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Course in Hematopathology, Jan. 28-30, VA Hospital, Tampa+

Annual Cardiovascular Seminar, Jan. 30-31, University of South Florida, Tampa+

Twenty-First Central Florida Medical Meeting, Jan. 28-Feb. 1, Orlando. For information: Howard E. Gross, M.D., 15 W. Columbia St., Orlando 32806

▶Clinical Gastroenterology and Endoscopy, Jan. 28-Feb. 4, Doral Country Club, Miami. For information: Am. Soc. for Gastrointestinal Endoscopy, Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

FEBRUARY

Update Gastroenterology: 1975, Feb. 1-2, Americana Hotel, Miami Beach*

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Practical Problems in Clinical Cardiology, Feb. 2-6, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 2-7, Americana Hotel, Miami Beach*

Tenth Annual Symposium on Cosmetic Surgery, Feb. 5-7, Cedars of Lebanon Health Care Center, Miami. For information: Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Advanced Skills—Sex Workshop, Feb. 5-8, Hyatt House, Orlando**

Midwinter Seminar in Obstetrics/Gynecology, Feb. 6-8, University of South Florida, Tampa+

Tumors of Infancy and Childhood, Feb. 6-8, All Children's Hospital, St. Petersburg+

Postgraduate Course in Clinical Allergy, Feb. 8-13, Sonesta Beach Hotel, Key Biscayne*

Second Annual USF Cancer Seminar, Feb. 14, Ft. Harrison Hotel, Clearwater+

Symposium in Perinatology, Feb. 18-20, University of Miami School of Medicine, Miami*

Immunological Mechanisms of Disease, Feb. 18-20, Hilton Hotel, Gainesville**

Medical Hypnosis for the Practicing Physician, Feb. 20, Aboard the SS Monarch*

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

Management of Nonsurgical Medical Emergencies, Feb. 25-27, University of South Florida, Tampa+

Cancer Conference: Diagnosis and Management of Ovarian Carcinoma, Feb. 27, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▶Contemporary Surgery, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▶Contemporary Ophthalmology, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Ophthalmology, 30 N. Michigan Ave., Chicago 60602

FEBRUARY Continued—

▶Contemporary Medicine 1976, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▶Selected Topics in Cutaneous Medicine, Feb. 29-Mar. 6, Diplomat Hotel, Hollywood, Florida. For information: N.W. Dermatologic Soc., 1150 David Whitney Bldg., Detroit, Michigan 48226

MARCH

Infant Nutrition, Mar. 4-5, University of South Florida, Tampa+

Selected Topics in Urology, Mar. 4-6, Hilton Hotel, Gainesville**

Fifth Annual Postgraduate Seminar in Dermatology, Mar. 5-7, Hyatt House, Miami Beach*

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Sheraton Four Ambassadors Hotel, Miami*

Annual Suncoast Trauma Seminar, Mar. 18-20, Holiday Inn, Tampa+

Advanced Life Support: The Fourth Annual Postgraduation Seminar in Emergency Medicine, Mar. 19-22, Americana Hotel, Miami Beach. For information: Registrar, 1976 PGS, 1919 Beachway Rd., Jacksonville 32207

6th Annual Special Procedures Seminar: How and Why We Do it (Radiology), Mar. 21-24, Hyatt House, Miami Beach*

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

Inflammatory Bowel Disease, Mar. 25, University of South Florida, Tampa+

Seventh Annual Topics in Internal Medicine, Mar. 25-27, Gainesville Hilton, Gainesville**

Topics in Adolescent Medicine for the Practicing Physician, Mar. 26, Aboard the SS Monarch*

Cancer Conference: Management of Bone Tumors, Mar. 26, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Post-Convention Seminar: Anatomic-Pathologic Correlations in Pulmonary & Gastrointestinal Diseases, Mar. 28-31, (Cruise)*

Diagnosis and Management of Obstructive Airways Disease, Mar. 29-30, University of South Florida, Tampa+

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

Symposium in Perinatology, Mar. 31-Apr. 3, Sonesta Beach Hotel, Key Biscayne*

Renal Disease & Hypertension, Mar. 31-Apr.3, Americana Hotel, Miami Beach*

APRIL

Spring Symposium in Intensive Care, Apr. 2-5, Carillon Hotel, Hollywood, Florida*

▶Office Management of the Infertile Couple, Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608-13th Ave. S., Birmingham, Al 35205

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Asymptomatic Coronary Artery Disease: Early Detection & Management, Apr. 22-23, Hyatt House, Orlando**

Cancer Conference: Cancer Detection in the Physician's Office, Apr. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▶Symposium in Cardiovascular Nursing, Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

MAY

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

▶Gastrointestinal Endoscopy, May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Third Annual Family Practice Review, May 31-June 4, Hilton Inn, Gainesville**

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

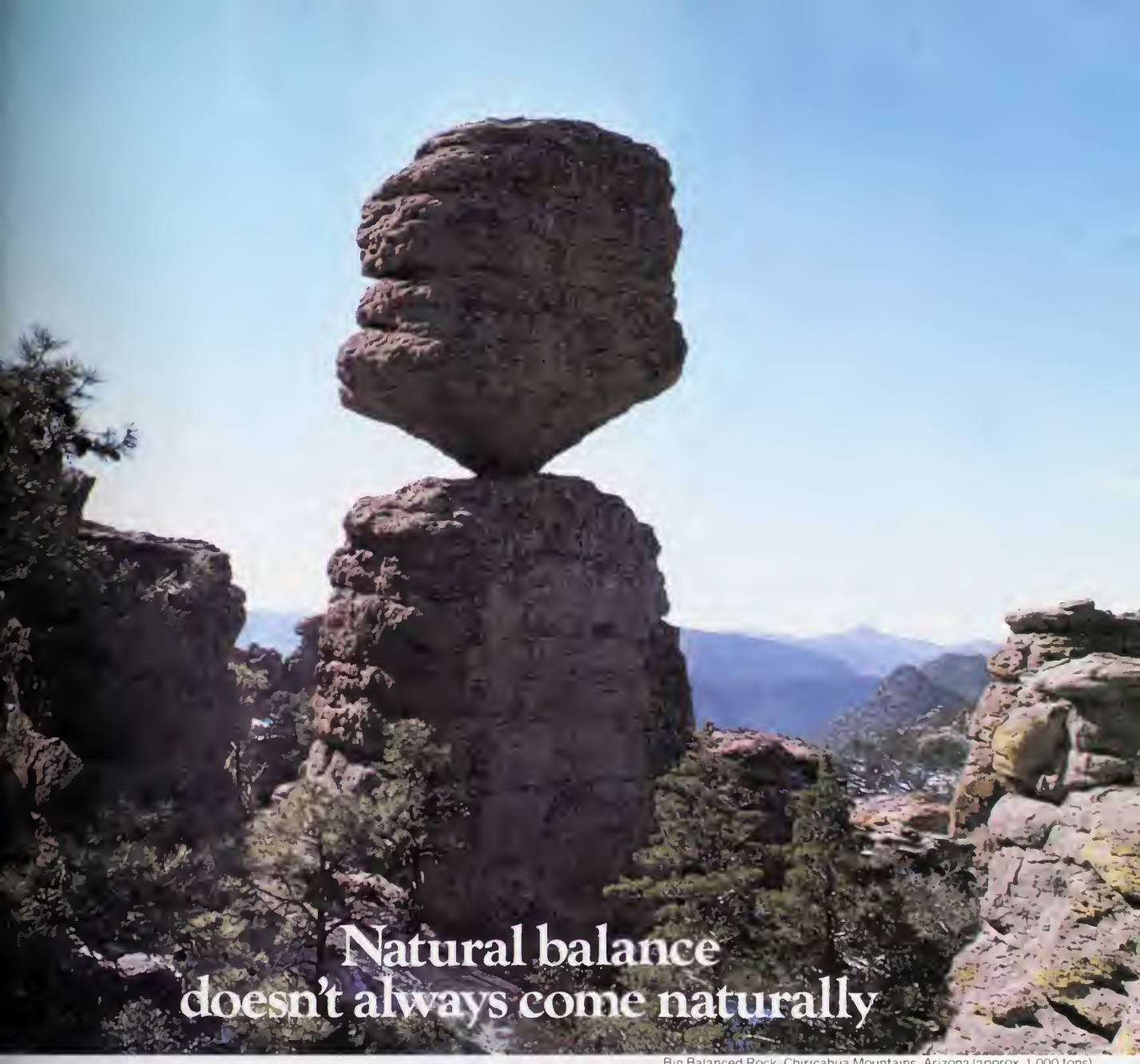
JUNE

Bascom Palmer Eye Institute Annual Residents Day, June 1976, Key Biscayne Hotel, Key Biscayne*

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with seases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored blets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for usea, vomiting and dizziness associated with motion sickness.

EF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of ciences—National Research Council and/or other information, FDA has classified he indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with notion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the estibular system.

Final classification of the less than effective indications requires further nvestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

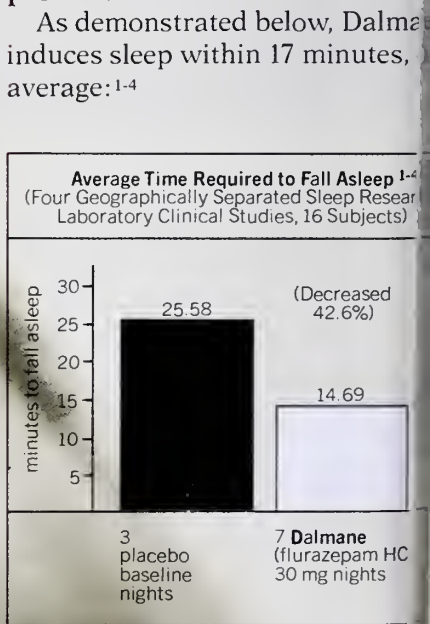
ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

How do you handle trouble falling asleep?

With Dalmane® (flurazepam HCl), results are highly predictable.

As demonstrated below, Dalmane induces sleep within 17 minutes, average:[1-4]



And for those with trouble staying asleep or sleeping long enough...

...sleep research laboratory clinical studies prove: Dalmane decreases number of nighttime awakenings and increases total sleep time.[5]

Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"

Dalmane is generally well tolerated. The usual adult dose of 30 mg should initially be lowered to 15 mg for the elderly and debilitated, to help preclude oversedation, dizziness or ataxia. Appraisal of possible risks is suggested before prescribing.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
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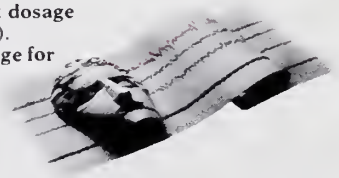

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patien package insert has been around fo a long time. Many physicians alrea use written instruction sheets to provide patients with information about the drugs they are taking. A some physicians give verbal instru tions; but in too many instances these are what I call eye-glazing ex ercises. I have seen patients sit wi glazed eyes listening to a rapid-fir lecture by a hurried physician wh has 20 people out in his waiting room. These patients aren't given sufficient understanding and ther fore do not follow instructions. So think the idea of an official packag insert for patients is a good one. Perhaps we should really think of this kind of information simply as extension of drug labeling.

The benefits of patient involvemen

Many physicians may not rea ize how frequently a patient obtai his drug information from Aunt Tillie or the next door neighbor. A this information is almost alway bad or irrelevant to the case at ha Furthermore, the incentive to go along with a prescribed program slim if the only reading matter the patient receives, along with his pr scription, is a bill.

As an educator I am impress by the principle that the best way get someone to do something is t involve him in the process. So the

I think there are advantages well as some real disadvantages i a patient package insert. When yo begin to use semi-medical or mec cal terms to describe complicatio or possible sequelae of disease o treatment, you may frighten the p tient—particularly since the more highly sophisticated patient is no the one who is going to read the i sert. The patient who will read it i the one most susceptible to frigh and confusion by the language.

On the positive side, a pack insert will probably give the patie better insight into why he is being treated the way he is, and it may give the physician a little bit mor time. But it does not remove fron the physician the need or obligat to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should b warned of the possibility of serio side reactions—to know what the real dangers are. But it doesn't d bit of good to indicate that a pati on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frigh engendered by the insert may po sibly outweigh the potential gooc

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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P·M·A

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Ortho-Novum SQ provides good cycle control

provides a low sequential dosage

effective in clinical trials, with a pregnancy rate of 0.43 per 100 woman years

generally well tolerated†

available in the unique DIALPAK* Tablet Dispenser

Ortho-Novum SQ

TRADEMARK

Each white tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

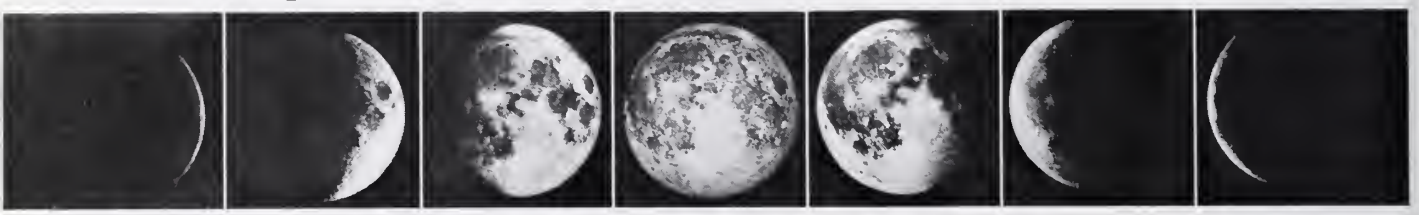
†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing information for this product.

*TRADEMARK

See prescribing information on following page.

OJ 622-5

In sequence...



Ortho-Novum SQ Tablets

TRADEMARK

Description. ORTHO-NOVUM SQ Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0.08 mg, and blue tablets containing both mestranol 0.08 mg and norethindrone 2.0 mg.

Action: Gonadotrophin suppression.

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy. Liver disease has also been reported, and the physician should be alert to its earliest manifestations.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication: Contraception.

Contraindications: 1. Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions. 2. Markedly impaired liver function. 3. Known or suspected carcinoma of the breast. 4. Known or suspected estrogen-dependent neoplasia. 5. Undiagnosed abnormal genital bleeding. 6. Known or suspected pregnancy.

Warnings: 1. The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis. Should any of these occur or be suspected, the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease: occlusive or hemorrhagic, and the use of oral contraceptives. There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country.[4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about seventold, while the United States studies found relative risks of 4.4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users.

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group. This study in its interim analysis states: "A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk." The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users. The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations.

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment.

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4.1 to 9.5 times greater in users than in non-users. A comparable estimate for hemorrhagic stroke was 2.0.

None of the American studies was designed to evaluate a difference between products. However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products.

Other retrospective studies[3,9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users. It has been recommended that therapy be discontinued at least one month prior to elective surgery.

2. Discontinue oral contraceptive medication if there is gradual or sudden partial or complete loss of vision; proptosis or diplopia; onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe; papilledema, or any evidence of retinal vascular lesions.

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy.[11,12] The safety of ORTHO-NOVUM SQ in pregnancy has not been demonstrated. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

5. Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed before prescribing oral contraceptives and periodically during their administration and should include special reference to breasts and pelvic organs, including Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. 2. Endocrine and possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ. Therefore, if such tests are abnormal in a patient taking ORTHO-NOVUM SQ, it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated. 6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 7. Any possible influence of prolonged ORTHO-NOVUM SQ therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORTHO-NOVUM SQ therapy. 9. The age of the patient constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ may mask the onset of the climacteric. 10. The pathologist should be advised of ORTHO-NOVUM SQ therapy when relevant specimens are submitted. 11. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids. 12. Cholestatic jaundice has been reported in users of oral contraceptives. If this occurs, ORTHO-NOVUM SQ should be discontinued. This condition is more likely to occur in patients who have experienced cholestatic jaundice of pregnancy. Patients with a history of cholestatic jaundice of pregnancy should be carefully observed during ORTHO-NOVUM SQ therapy.

Adverse reactions observed in patients receiving oral contraceptives: A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism, cerebral thrombosis and hemorrhage, gallbladder disease.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis; hepatic lesions with or without intra-abdominal bleeding.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, rash (allergic), mental depression, change in weight (increase or decrease), breast changes (tenderness, enlargement and secretion), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, rise in blood pressure in susceptible individuals.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post-treatment, which tends to occur more frequently in women with a history of menstrual disorders; premenstrual-like syndrome; changes in libido, changes in appetite, cystitis-like syndrome, headache, intolerance to contact lenses, nervousness, dizziness, fatigue; backache; hirsutism, loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruptions; itching; vaginitis.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function—increased sulfobromophthalein retention and other tests; coagulation tests—increase in prothrombin, Factors VII, VIII, IX and X; decrease in anti-thrombin III; increase in platelet aggregability; thyroid function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

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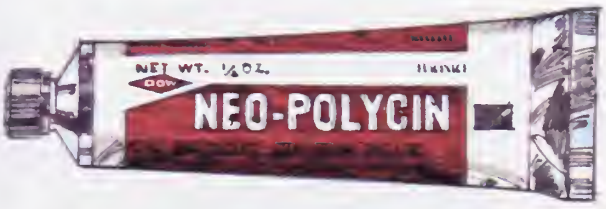

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ELEVENTH ANNUAL

POSTGRADUATE COURSE

"INTERNAL MEDICINE 1976"

January 25-30, 1976

Fontainebleau Hotel — Miami Beach, Florida

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Program Coordinator:
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THE OBJECT OF THIS COURSE, THE ELEVENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS. EACH SUBSPECIALTY WILL BE INTRODUCED BY A STATE OF THE ART LECTURE GIVEN BY A DISTINGUISHED AUTHORITY.

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J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia, Cardiovascular Diseases.

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Louis Weinstein, Ph.D., M.D., Visiting Professor of Medicine, Harvard Medical School, Physician, Peter Bent Brigham Hospital, Boston, Massachusetts, Infectious Diseases.

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Alcohol	0.75%

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See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

CHILD MENTAL HEALTH UNIT OPENS IN ATLANTA

The first private, comprehensive in-patient psychiatric service for children in Georgia has opened at Peachtree and Parkwood Mental Health Center and Hospitals in Atlanta, Georgia. Out-patient services and a day-care program are an integral part of this new service for children under 13 years of age.

TREATMENT PLAN

A multi-modality approach to psychiatric treatment is used and a comprehensive treatment plan is developed for each child. Psychiatric history, physical and neurological examinations, social history, educational evaluation and psychological testing determine the basic data upon which a treatment plan is devised.

The following types of treatment are used: individual psychotherapy (play therapy); group activities and group therapy; chemotherapy; parents and family therapy, and occupational, recreational, and music therapies. Special emphasis is placed on the family therapy process and treatment involves the family at every step.

MEDICAL SERVICES

Each child admitted receives a complete physical and neurological examination performed by the Center's pediatrician. This includes a medical history and necessary laboratory procedures, such as EEG, EKG, and fluoroscopic X-ray studies.

STAFF

The new Child Service is directed by a fully-trained child psychiatrist who has had previous experience with the direction of a child unit. Ten child psychiatrists and several child psychologists are involved in the program, and the staff works as a team in diagnosis, treatment and rehabilitation under the direction of a child psychiatrist.

NEEDED SCHOOLING AVAILABLE

An educational evaluation determines the prescriptive teaching each child requires in the special educational program which is provided.

Peachtree and Parkwood is a comprehensive mental health center which includes alcohol rehabilitation and drug treatment as well as psychiatric treatment for adults, adolescents and children. Complete information on services and facilities may be obtained by writing or calling the Admissions Director:

PEACHTREE and PARKWOOD MENTAL HEALTH CENTER and HOSPITALS

1999 Cliff Valley Way, N.E. Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

There's something special about children vomitin

The risk of dehydration . . . plus the psychological stress on both mother and child . . . greatly increases the urgency in controlling vomiting in children. In addition, there is, of course, need to avoid the extrapyramidal problems associated with phenothiazine medications.

That's why special medication is preferred

WANS® CHILDREN SUPPRETTES™ are specially formulated to stop vomiting and nausea in children—rapidly and with minimal complications.

- WANS are administered rectally—often the best route in the vomiting patient.
- The exclusive WANS formula provides both pyrilamine maleate and sodium pentobarbital for effectiveness . . . contains no phenothiazines or local anesthetics.
- The unique Supprette delivery system rapidly releases effective levels of medication . . . with no oils or fatty acids to affect absorption or cause local irritation.
- WANS SUPPRETTES require no refrigeration . . . no lubrication other than water . . . and dissolve completely, with virtually no leakage.

And for children over 12 years of age and adults suffering from nausea and vomiting, consider higher-strength WANS® No. 1 or WANS® No. 2.

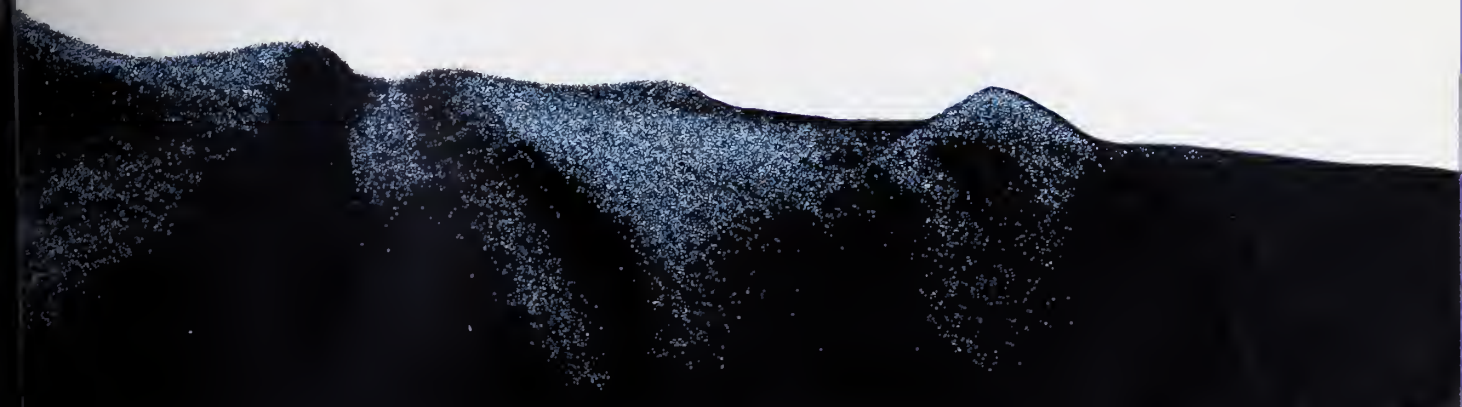
A special favorite* of Florida physicians in controlling childhood vomiting

WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg, sodium pentobarbital 30 mg
Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization



DESCRIPTION: WANS* Children: (Blue) pyrilamine maleate 25 mg and pentobarbital sodium* ½ gr (30 mg) scored for ½ dosage. WANS* No. 1: (Pink) pyrilamine maleate 50 mg and pentobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. WANS* No. 2: (Yellow) pyrilamine maleate 50 mg and pentobarbital sodium* 1½ gr (100 mg) scored for ½ dosage.

WARNING: may be habit forming.

CONTRAINDICATIONS: Infants under 6 months. Acute intermittent porphyria, known hypersensitivity to barbiturates or antihistamines, known previous barbiturate addiction, severe hepatic impairment, CNS injury, senility, and presence of uncontrolled pain.

WARNINGS: Barbiturates may be habit forming. Pre-existing psychologic disturbances may be aggravated. Idiosyncratic reactions may occur. Acquired sensitivity may result in allergic reactions. Safety in pregnancy has not been established.

PRECAUTIONS: Use cautiously with other sedative, hypnotic or narcotic agents. Use with caution in patients with acute or chronic hepatic disease, fever, hyperthyroidism, diabetes mellitus, severe anemia, congestive heart failure, or a history of drug dependence or suicidal tendencies. May impair alertness and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

Webcon Pharmaceutical Division
Alcon Laboratories, Inc.
Fort Worth, Texas 76101

A SCIENTIFIC EXHIBIT . . . prepared by three members of the staff of Miami's Bascom Palmer Eye Institute won the third place medallion at the Annual Meeting of the American Academy of Ophthalmology and Otolaryngology in Dallas.

The award was made to Richard K. Forster, M.D., Gerbert C. Rebell and Fernando G. Gonzalez for an exhibit entitled "Fungal Keratitis—Diagnosis, Treatment and Research."

SOUTH FLORIDA PHYSICIANS HAVE GIVEN . . . a 63 percent vote of confidence to the Dade-Monroe Professional Standards Review Organization (PSRO).

In a government-sponsored referendum among physicians in the two counties in September, 1,440 physicians supported the PSRO, while 845 opposed it. The PSRO is negotiating with the U.S. Department of Health, Education and Welfare for the monitoring of Medicare and Medicaid cases.

The reviewing organization could become operational early in 1976.

FLORIDA NURSING HOME ASSOCIATION has elected Arthur H. Harris of Orlando as its President. Mr. Harris, Administrator of Florida Manor, succeeds John M. Jenkins.

A POSTGRADUATE COURSE . . . on Prevention and Control of Hospital-Associated Infections will be a feature of the 69th Annual Scientific Meeting of the Southern Medical Association (SMA) this month. The course will be conducted on November 16 at the Hotel Fontainebleau in Miami Beach with the co-sponsorship of the American Society of Clinical Pathology, the Florida Society of Pathologists and the SMA Section on Medicine.

AMERICAN DIABETES ASSOCIATION'S . . . Florida Affiliate has opened a permanent state headquarters and hired a full-time Executive Director.

Harold E. Aldrich Jr., of Jacksonville, 29-year-old graduate of the University of Florida, is the Executive Director, responsible for implementing the Association's education, disease detection and fund-raising programs throughout the state, according to ADA-Florida President John T. Blackburn, M.D., of Melbourne.

The Association will maintain an office in Suite 4, 1100 Cesery Blvd., Jacksonville 32211.

LEO M. WACHTEL, M.D. . . . of Jacksonville, has been elected Vice President of the American Academy of Family Physicians. Dr. Wachtel, President of the Florida Medical Association in 1960, was chosen by the 37,000 member Academy's Congress of Delegates in Chicago on October 6.

Liberty and Justice for All

INCLUDES RETARDED CITIZENS

national association for retarded citizens

Contact:
National Association for Retarded Citizens
2709 Ave. E. East, Arlington, Texas 76011
Area Code: (817) 261-4961

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

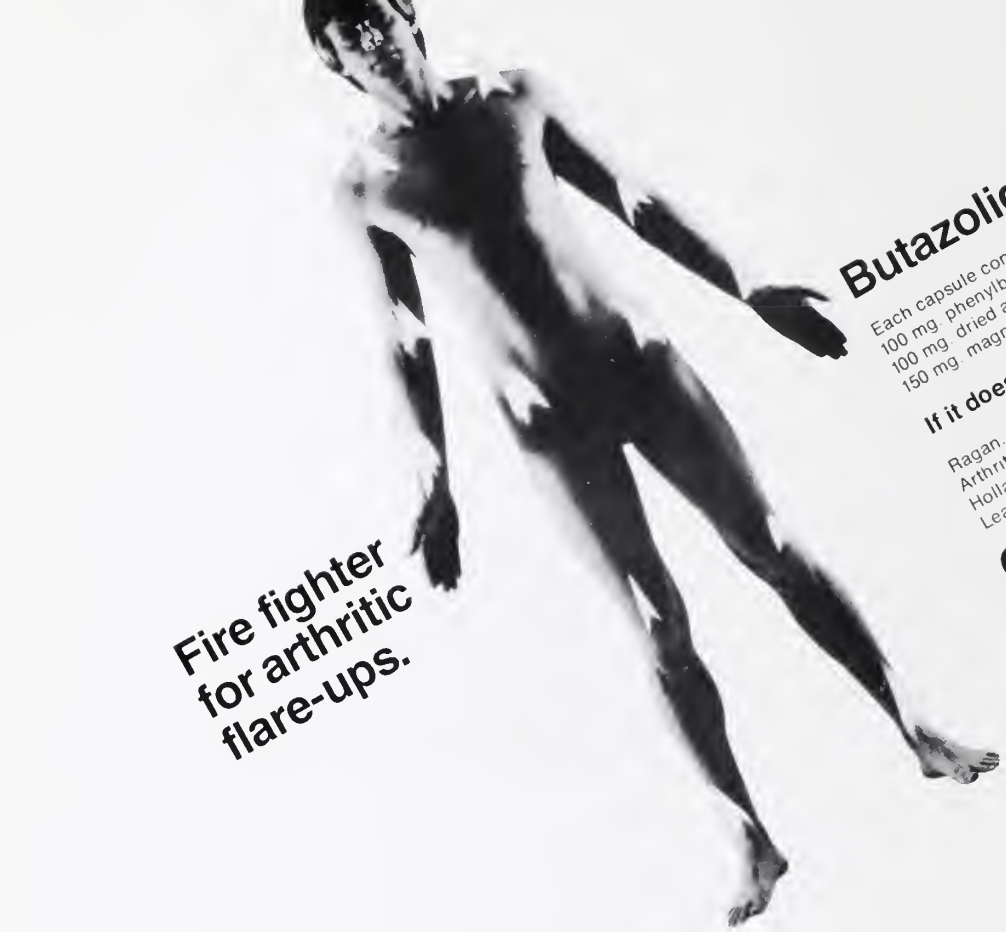
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy, blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension, thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions. This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema*: That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension.* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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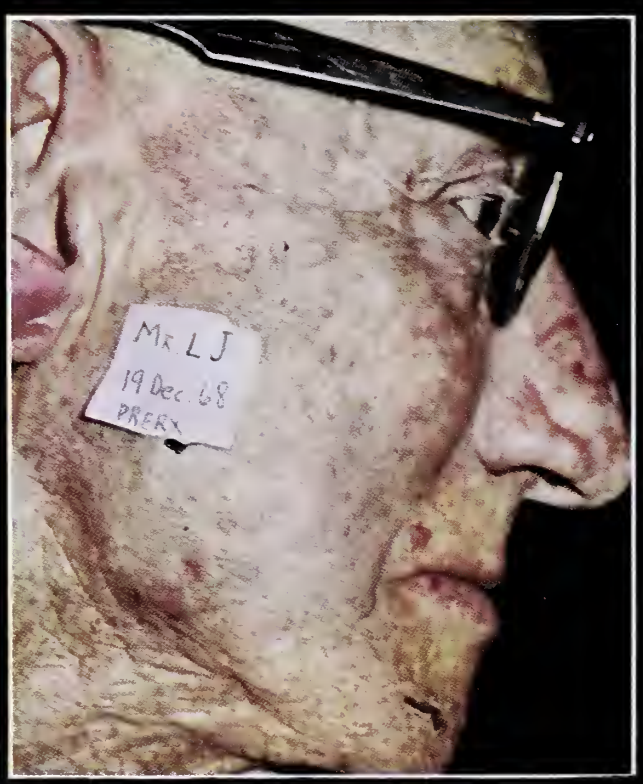

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NOVEMBER, 1975 • VOLUME 62 • NUMBER 11

Management of the Asymptomatic Patient With a Positive Stress Test

C. RICHARD CONTI, M.D.

Abstract: A 52-year-old asymptomatic engineer is presented who developed an abnormal ST segment response to treadmill exercise testing. The paper summarizes an approach to the investigation of this problem which includes ruling out false positive stress tests related to left ventricular hypertrophy, digitalis effect, vasoregulatory problems, and hyperventilation.

This case illustrates the importance of performing a hemodynamic evaluation which will provide correlation of the anatomic, physiologic and metabolic abnormalities in a patient with so-called "ischemic electrocardiographic" response to stress. The patient presented had angiographically normal coronary arteries. Thus, we can say with some degree of confidence that the patient's prognosis for life is excellent.

Guidelines are recommended for the management of subsets of asymptomatic patients with a positive stress test who have coronary occlusive disease.

The problem of what to do with a patient with a positive stress test who has no symptoms has been brought into sharp focus recently because of the increasing widespread use of the treadmill stress test. Many businesses insist that young executives have annual stress tests. In addition, some insurance companies require an exercise test as part of the evaluation of the insurance risk. I am confident that the future will produce an increasing number of problems related to the interpretation and clinical significance of a "positive" exercise test in the asymptomatic individual. This report summarizes an experience with such a patient who recently was evaluated at the University of Florida.

Dr. Conti is Professor of Medicine and Chief of the Division of Cardiology at the University of Florida College of Medicine, Gainesville.

Case Presentation

The patient is a 52-year-old white male NASA engineer who had been in good health all his life but was discovered to have systemic hypertension approximately seven years ago. This was treated with Enduronyl and Valium successfully. The patient denied any angina and had no history of congestive heart failure. The patient was referred for evaluation because his private physician performed an exercise test and although the patient had no subjective symptoms during the stress test, he did have ST segment depression in the precordial leads during and after exercise. On physical examination blood pressure was 140/88, weight 196 lbs., and height 72 inches. There were Grade 1 retinal changes and a Grade 1 out of 6 ejection systolic murmur with an intermittent fourth heart sound at the lower left sternal border but no cardiomegaly on examination. Chest x-ray revealed normal heart size, clear lungs and a normal ascending aorta. The stress test was repeated using the Bruce protocol and at stage 2 at 2.5 mph at 12% grade, a heart rate of 148 beats per minute was attained after seven minutes of total exercise. During this stress test the subject developed a typical ischemic electrocardiographic response to stress although he complained of no symptoms. The standing pre-exercise electrocardiogram is shown in Figure 1. Figure 2 shows ST segment changes in V4, V5 and V6 during Stage 2 exercise. The stress test was discontinued at this point, however, the patient had no symptoms. Figure 3, ECG taken one minute postexercise reveals persistent ST segment depression. Ten minutes later the tracings were back to control.

Approach to Investigation of the Problem

The clinical significance of a positive ischemic response to stress in an asymptomatic person is unknown. In my view, this finding clearly warrants further investigation. One must first rule

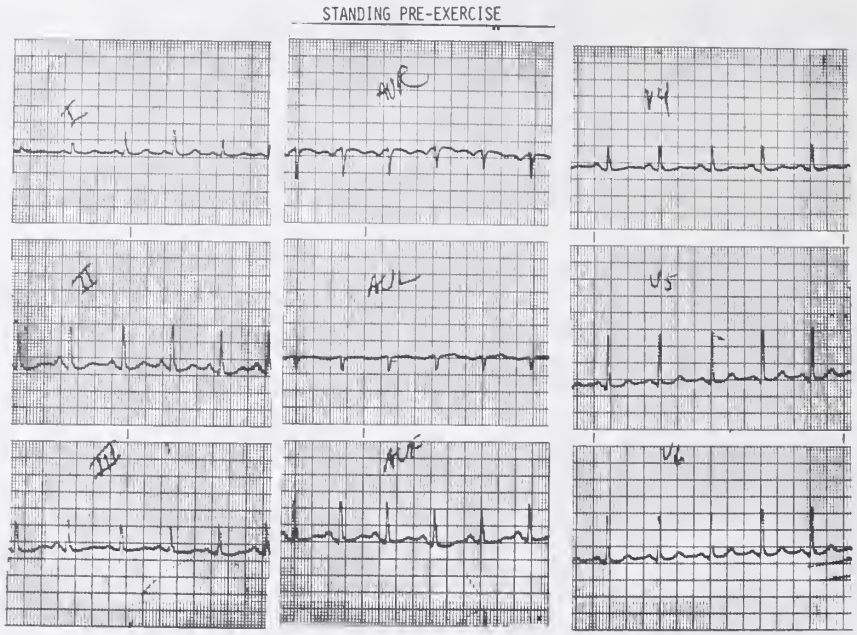

Fig. 1.—Standing pre-exercise electrocardiogram.

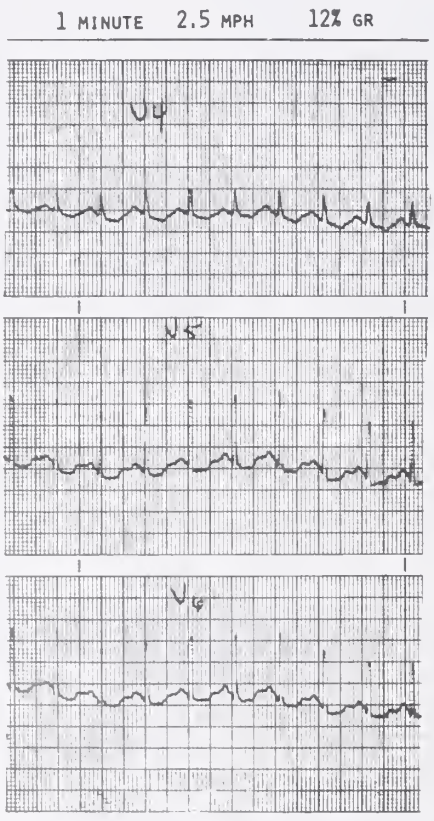

Fig. 2.—Precordial leads V_4, V_5 and V_6 taken during exercise at 2.5 mph and 12% grade. Note ST segment depression.

out the obvious "false positive" stress test, e.g. (1) patients with LVH secondary to hypertrophic subaortic stenosis, aortic stenosis, or systemic hypertension, (2) patients taking digitalis, (3) patients with the syndrome of vasoregulatory asthenia,[1] and (4) patients who develop an "ischemic electrocardiographic response" to hyperventilation.[2] This patient had no clinical evidence of LVH and was not taking digitalis. Figure 4 illustrates the effect of hyperventilation on this patient's electrocardiogram. There was some ST segment depression but it is not a clearly square wave or down sloping ST segment depression and this was not considered as an unequivocably positive ischemic electrocardiographic response.

It may be useful clinically to repeat the stress test after sublingual nitroglycerin administration. This patient was given sublingual nitroglycerin and Figure 5 illustrates the electrocardiographic changes after nine minutes of total exercise and after three minutes at 2.5 mph at 12% grade. This stress test is very similar to the one obtained prior to giving nitroglycerin.

The observation that there was no significant change in the electrocardiogram after nitroglycerin administration followed by stress should make one suspicious that this may be a false positive test but one can never be certain.

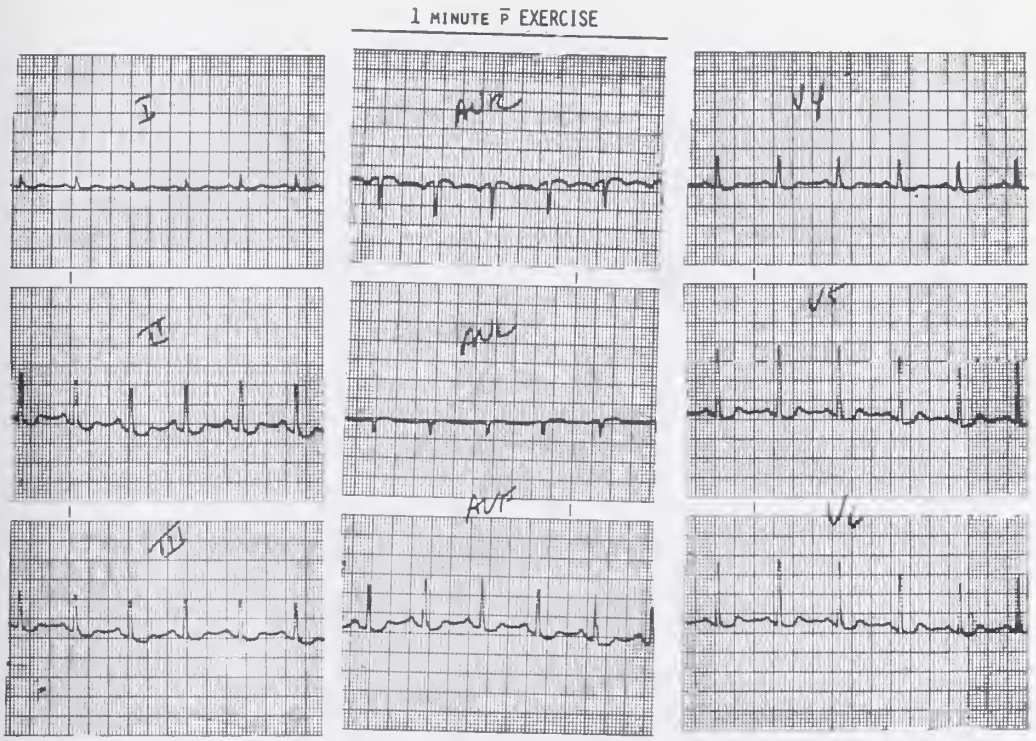

Fig. 3.—Postexercise ECG: Not persistent ST segment depression in V_5 and V_6.

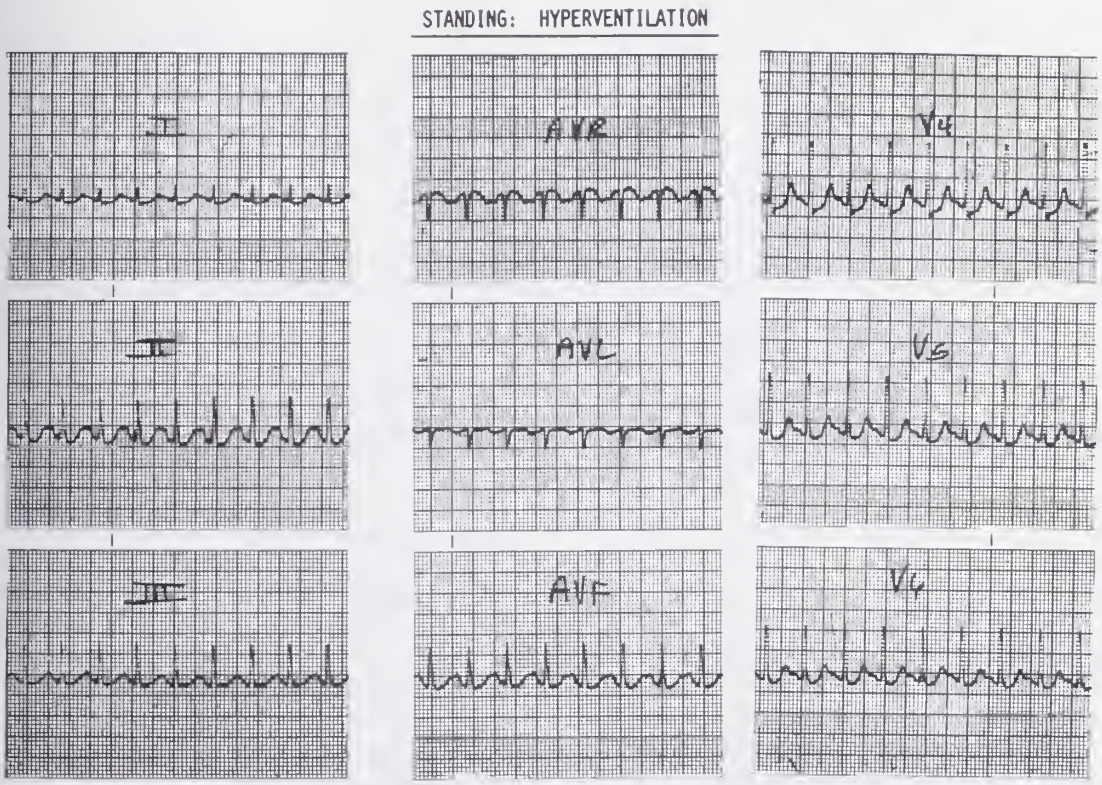

Fig. 4.—ECG taken during hyperventilation. Note ST segment depression in V_5 and V_6.

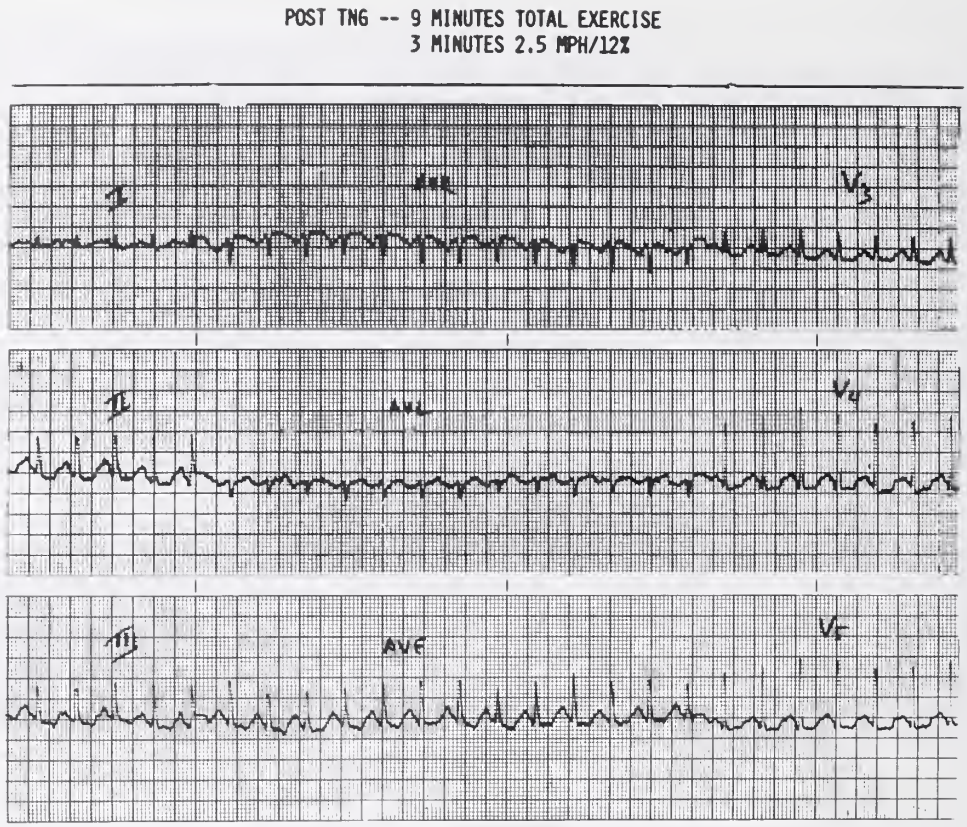

Fig. 5.—In exercise electrocardiogram following the administration of sublingual nitroglycerin.

In order to determine the meaning and clinical significance of these stress related electrocardiographic changes, it is necessary to perform a hemodynamic evaluation. This will provide correlation of the anatomic, physiologic and metabolic abnormalities in these patients with "ischemic" electrocardiographic responses to stress. The investigation should consist of ventriculography and coronary arteriography but should also include a pacing stress test with careful attention to symptoms, electrocardiographic abnormalities, left ventricular systolic and end diastolic pressure and myocardial lactate metabolism. The results of such an evaluation in this patient are summarized in Table 1. The three columns summarize the control data, observations during atrial pacing at a rate of 160 beats per minute, and observations in the postpacing period at a heart rate of 85. Systolic and left ventricular end diastolic pressure did not change significantly with pacing. The lactate extraction remained essentially the same in all three states. Clearly the only significant changes during pacing were the ST segments depressions of 2mm in V4 at a time when the patient had no symptoms. Based on these data, I would anticipate that this patient's electrocardiographic response to exercise and pacing might not be related to myocardial ischemia.

Ventriculography revealed normal end diastolic volume, normal ejection fraction and slight hypertrophy of the papillary muscles. Selective injections of the left coronary artery in the LAO and RAO projection were normal, as were selective injections of the right coronary artery in LAO and RAO projections.

Discussion

Fortunately, in this patient, the decision concerning future management was simple and should consist of observation and enthusiastic optimism.

Table 1.—Cardiac Catheterization

	Rest	Pacing	Postpacing
Heart Rate	90	160	85
L. Vent. Pressure	155/0-10	147/0-10	155/0-10
Aortic Pressure	155/90(120)		
ST Segment Shift	0	2mm $\downarrow V_4$	0.5mm $\downarrow V_4$
Chest Pain	0	0	0
Lactate Extraction	49%	46% 36%	46%

Based on other information about the natural history of coronary artery disease, we can state with some degree of confidence that this man's prognosis for life is excellent.[3] If on the other hand, coronary arteriography had revealed coronary occlusive disease the decision about future management may have been difficult. The finding of coronary artery occlusive disease does pose a somewhat different problem. Table 2 summarizes eight theoretical subsets that may arise in the asymptomatic patient with a positive stress test who has coronary occlusive disease. These conditions are listed in the left-hand column and the treatment options that are available to us in the two right-hand columns. These theoretical patient populations are divided into eight groups based on presence or absence of risk factors, e.g., smoking and hypertension, abnormal myocardial lactate metabolism, single or multiple vessel coronary occlusive disease.

At present there are no solid guidelines to which a physician can refer to help him make a logical decision about the future management of these patients. All natural history information (electrocardiography, risk factors, angiographic) has been reported in symptomatic subjects. However, if one extrapolates the natural history studies in these symptomatic patients based on coronary arteriographic studies then it would seem that subjects with multiple vessel disease have a higher risk of dying in five years than do patients with single vessel disease. If this be the case, then only patients with multiple vessel disease should be considered for a surgical procedure.

TABLE 2.—ASYMPTOMATIC PATIENT, POSITIVE STRESS TEST.

CONDITION	TREATMENT OPTIONS	
	OBSERVATION	SURGERY
(—) Risk Factors (—) Lactate		
Single Vessel	+	
Multiple Vessels	+	
(+) Risk Factors (—) Lactate		
Single Vessel	+	
Multiple Vessels	+	?
(+) Risk Factors (+) Lactate		
Single Vessel	+	
Multiple Vessels		+
(—) Risk Factors (+) Lactate		
Single Vessel	+	
Multiple Vessels	?	+

To summarize my views on the management of these patients, I recommend observation of patients with single vessel disease despite the presence of risk factors and/or abnormal lactate metabolism. I would probably recommend surgery in patients with multiple proximal vessel disease in whom we can demonstrate abnormal lactate metabolism associated with stress irregardless of the presence or absence of risk factors.

These guidelines are not meant to be rigid and are subject to change as more information about the natural history of this group of individuals becomes available. However, if physicians are expected to make decisions concerning medical or surgical management of patients with coronary occlusive disease, we should attempt to relate abnormal coronary anatomy to abnormal myocardial function and metabolism. At the present time, this relationship can only be determined in cardiac catheterization laboratories in which stress testing, multiple lead ECG monitoring and myocardial lactate studies are available.

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Carotid Endarterectomy in the Treatment of Transient Cerebral Ischemia

Daniel B. Nunn, M.D.

Abstract: This paper offers a computed-assisted analysis of 170 carotid endarterectomies in 152 patients with transient ischemic attacks (TIA). The patients' ages, sex, smoking habits, symptoms, carotid bruits, arteriographic findings, and associated diseases are summarized. All operative procedures were performed using general anesthesia, systemic heparinization, and a temporary intra-arterial shunt for cerebral support.

After surgery, transient neurologic deficits were noted in five patients and permanent neurologic deficits in four (2.4% incidence). The operative mortality for the series was 1.2% (one cardiac and one cerebral deaths).

A 100% late follow-up with the average period being 39 months revealed 96% of long-term survivors functionally normal or improved. There were 52 late deaths with heart disease accounting for 58% and stroke 17%.

Although the relationship between cerebral ischemia and the presence of extracranial arterial occlusive disease had been noted by several physicians during the latter half of the 1800s and the early 1900s,[1-5] it was 1953 before the first successful carotid endarterectomy was performed by Dr. Michael E. DeBakey.[6] Nevertheless, the first report by DeBakey and his colleagues on this subject did not appear in the literature until 1958.[7] Meanwhile, in 1954, Eastcott, Pickering, and Rob stimulated the development of carotid artery surgery for occlusive disease when they reported the successful reconstruction of a stenosed internal carotid artery.[8] Since then, carotid endarterectomy has become the standard operative procedure for selected patients with cerebrovascular insufficiency caused by arteriosclerotic involvement of the proximal internal carotid artery. Numerous reports have demonstrated the efficacy of this procedure and have indicated that the patient with transient ischemic attacks (TIA) is the ideal candidate for operation.

This paper presents a computer-assisted analysis of the author's experience with carotid endarterectomy in the treatment of patients diagnosed as having TIA. The results of this retrospective study are collated with those reported by other physicians and surgeons.

Material and Methods

From July 1963 to July 1973, a total of 234 carotid endarterectomies were performed; 170 endarterectomies were done for arteriosclerotic narrowing and ulcerated plaques in 152 patients with TIA. Bilateral operations were performed in 18 patients, and in each patient the procedures were staged at least one week apart.

Carotid arteriograms were made under local anesthesia and sedation in all patients. In most patients, a percutaneous puncture technique was used. Vertebral arteriograms were not made unless clinical findings indicated vertebral or basilar arterial insufficiency. The other patients underwent selective carotid arteriography as part of a three or four vessel catheter study performed by the transfemoral Seldinger technique. Hypaque 50% or Renografin-60 contrast material was injected manually, and serial films were taken with an Elema-Schonander x-ray unit.

All operative procedures were performed under general endotracheal anesthesia, and blood pressure was maintained near preoperative levels; hypercarbia was avoided. Each patient was given 5,000 units of heparin intravenously at least five minutes before occluding the carotid artery with vascular clamps. A temporary intra-arterial shunt was utilized during all endarterectomies, and the arteriotomies were closed with continuous 6-0 Dacron sutures without the use of a patch. Heparin was neutralized with protamine sulfate only during the latter part of the series in those pa-

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tients in whom there had been significant hypertension or considerable bleeding from the wound surfaces. Postoperative anticoagulants were not used.

Operative mortality was defined as death which occurred in the course of the operation, during the postoperative hospitalization period, or within 30 days after surgery.

Follow-up examinations were made at regular intervals and at the conclusion of the study. If death occurred prior to the end of the study, the date and the cause of death were determined along with the clinical condition of the patient. Late results of surgery were evaluated on the basis of the patient's functional status—normal, improved, same, worse, or normal or improved then worse.

The operative cases were analyzed in the following manner. A data extraction worksheet was designed to contain a numerial list of items which could be used to describe the salient features of each case. After reviewing a patient's records, items pertaining to that particular case were identified by circling the appropriate numbers on a separate worksheet; the worksheet was then completed by assigning the case a series number and listing the patient's age and the follow-up period in months. Information recorded on the worksheets was keypunched on data cards, and a computer programmed to read the cards and store the information on disk packs. Another program enabled the computer to analyze the stored information and provide specific answers to questions of interest.

Clinical and Arteriographic Findings

The 152 patients in this series included 94 males and 58 females; 146 patients were Caucasians and six were Negroes. The patients' ages ranged from 32 to 88 years, and the average age was 65 years.

Information regarding smoking, available in the records of 133 patients, revealed 81 smokers and 52 non-smokers. A non-smoker was defined as one who either had never smoked or had not smoked for at least two years prior to carotid endarterectomy.

Patients experienced a variety of symptoms attributed to cerebrovascular insufficiency. A complete list of symptoms (Table 1) comprised unilateral motor weakness, unilateral sensory deficit, amaurosis fugax, aphasia, dysarthria, dizziness, vertigo, syncope, diplopia, tinnitus, and photopsia. Those which occurred more frequently were dizziness (66%), amaurosis fugax (31%), unilateral motor weakness (30%), and aphasia and dysarthria (21% total).

Table 1

SYMPTOMS	PERCENT OCCURRENCE
Unilateral motor weakness	30%
Unilateral sensory deficit	10%
Amaurosis fugax	31%
Aphasia	5%
Dysarthria	16%
Dizziness	66%
Vertigo	6%
Syncope	19%
Diplopia	6%
Tinnitus	19%
Photopsia	5%

Preoperatively, a systolic bruit was audible over the carotid artery subjected to endarterectomy in 73 (43%) of the 170 operative cases. In 18 of the cases (11%), a bruit was detected over the inappropriate artery only; 29 (17%) cases had a bruit over both carotid arteries.

Significant medical abnormalities other than cerebrovascular insufficiency were found in 155 (91%) of the operative cases. The associated diseases and their incidence are listed in Table 2.

The preoperative carotid arteriographic findings for both the appropriate and inappropriate arteries in all cases are summarized in Table 3. With regard to findings in the appropriate carotid arteries, there were 12 cases with stenosis less than 50%, five cases with stenosis less than 50% and an ulcerated plaque, 150 cases with stenosis 50% or greater with or without an ulcerated plaque, and three cases with an ulcerated plaque alone.

Vertebral arteriograms were made in 40 of the operative cases. Only one serious complication resulted from all arteriographic studies. Acute thrombosis of a carotid artery developed during percutaneous carotid arteriography in a patient with severe stenosis; fortunately, following emergency thromboendarterectomy with successful restoration of flow, there were no neurologic sequelae.

Table 2

ASSOCIATED DISEASE	PERCENT OCCURRENCE
Diabetes mellitus	17%
Hyperlipidemia	24%
Hypertension	50%
Heart disease	41%
Vertebral artery insufficiency	6%
Cerebral occlusive disease	20%
Cerebral aneurysm	4%
Vascular disease of lower extremities	46%
Chronic bronchitis and pulmonary emphysema	14%

Table 3

ARTERIOGRAPHIC FINDINGS	APPROPRIATE ARTERY	INAPPROPRIATE ARTERY
Stenosis less than 50%	12	41
Stenosis less than 50% with ulcerated plaque	5	6
Stenosis 50% or greater with or without ulcerated plaque	150	38
Ulcerated plaque alone	3	5
Complete occlusion		17
Normal		46
No arteriogram		17

Results of Surgery

Five patients required emergency reoperation because of postoperative hemorrhage. All had hypertension, and none received protamine sulfate following the use of heparin. The hemorrhage occurred within 1-3 hours after the endarterectomy. In four patients, there was excessive capillary bleeding from the skin and subcutaneous tissues alone; postoperative thrombosis of the internal carotid developed in the other patient and bleeding occurred from the arterial suture line. Except for the postoperative death in the patient with carotid thrombosis, the others recovered without ill effects.

After carotid endarterectomy, transient neurologic deficits were noted in five cases, permanent deficits followed four operations (2.4% incidence). Factors contributing to the development of postoperative neurologic deficits included operative hypotension, postoperative hypertension, presence of cerebral and contralateral carotid occlusive disease, and the unintentional compression of the operated carotid while elevating the mandible to prevent respiratory obstruction.

Two deaths (one cardiac and one cerebral) occurred within 30 days after surgery (1.2% operative mortality); no deaths occurred in the course of the operative procedure.

A 100% late follow-up was obtained and the average period of follow-up was 39 months. The details of follow-up in terms of months and number of cases are depicted in Table 4.

The functional status of the surviving operative cases either at the completion of the study or prior to late death is shown in Table 5. Ninety-six per cent of the cases were judged functionally normal or improved.

A total of 52 late deaths occurred during the follow-up period (Table 6). The majority of deaths (58%) were caused by heart disease; 17% were attributed to stroke.

In this series, there were no postoperative wound infections, no postoperative aneurysms at the site of endarterectomy, and none of the patients required reoperation for recurrent carotid arteriosclerosis.

Discussion

Data from the Joint Study of Extracranial Arterial Occlusion,[9] a cooperative project among 24 institutions, indicated that approximately 75% of patients with ischemic cerebrovascular disease have at least one significant stenotic lesion in the extracranial vasculature at a surgically accessible site. An analysis of these patients failed to show a statistical difference between males and females; there was, however, a higher proportion of accessible lesions in Caucasians.

In the series presented, a systolic bruit was audible over the carotid artery subjected to endarterectomy in 43% of the cases. By comparison with other series, this would appear to be an unusually low incidence. DeWeese[10] found carotid bruits in 77% of 313 patients who underwent endarterectomy. Also, studies by Kartchner and McRae[11] revealed that at least 88% of patients with significant carotid lesions will have bruits when visual audiofrequency techniques are used for detection. Concerning the importance of carotid bruits, it should be noted that there is a high degree of correlation between such bruits and the presence of stenotic plaques in the internal carotid arteries in cases with overt cerebrovascular insufficiency.[12]

Symptoms and signs of cerebrovascular insufficiency may be caused by alterations in cerebral blood flow due to either a hemodynamically significant stenosis of the carotid artery or platelet and atheromatous emboli eminating from ulcerated or irregular carotid plaques; platelet and atheromatous embolization is probably the more common etiologic factor.

It is generally agreed that arteriographic findings of at least 50% carotid stenosis (without

complete occlusion) or an ulcerated or irregular carotid plaque should be considered a surgical lesion if the patient's symptoms are related to the involved artery. Whenever bilateral disease is present, most surgeons elect to operate initially upon the artery with the greater degree of stenosis; if bilateral stenosis is essentially equal, endarterectomy is usually performed first on the vessel supplying the nondominant hemisphere. Bilateral procedures are always staged one or more weeks apart. Carotid endarterectomy is not indicated in patients with severe disability from a previous stroke and patients with far-advanced coronary arteriosclerosis.

Following the 170 carotid endarterectomies in this series, there was a 2.4% incidence of permanent neurologic deficits related to operation and a 1.2% operative mortality. These results compare favorably with those reported by other investigators. After 378 endarterectomies in which general anesthesia and a shunt were utilized, Thompson[13] noted a 2.1% incidence of permanent deficits and a 1.1% operative mortality. DeWeese et al[10] performed 237 operations under general anesthesia and maintenance of normal or slightly hypertensive blood pressure without a shunt; they reported 9% permanent deficits and a mortality rate of 2%. Fields et al[11] reporting for the Joint Study of Extracranial Arterial Occlusion reviewed 169 operations in which various methods were used to prevent operative cerebral ischemia; the incidence of permanent deficits was 7.7% and the operative mortality 3.5%.

The purpose of carotid endarterectomy in the treatment of patients with TIA is to prevent, or at least decrease, further transient ischemic attacks and to obviate the development of a completed stroke. Fifty one per cent of the patients in this study did not experience postoperative TIA and 45% of the patients had fewer attacks than prior to operation. The work of the Joint Study has shown that when TIA occurred in surgically treated patients, the disturbance is usually referred to the territory of an artery other than the one operated upon.[14] According to Thompson,[6] approximately 35% of untreated patients with TIA developed completed strokes if observed up to five years. In another study, Acheson and Hutchinson[15] reported the occurrence of completed strokes in 62% of 151 patients with TIA. Results of late follow-up, averaging 39 months, in this series revealed that only ten patients (5.8%) developed completed strokes.

TABLE 4. — LATE FOLLOW-UP ANALYSIS

Number of Months	6	12	18	24	30	36	42	48	54	60	66	72	78	84	90	96	102	108	112	118	120	TOTAL NUMBER CASES	AVERAGE MONTHS FOLLOW-UP
Number of Cases	27	8	16	13	17	13	17	14	16	6	1	4	2	3	2	4	1	1	1	1	1	168	39

TABLE 5

	NUMBER OF CASES AND PERCENT OCCURRENCE
Functionally normal	84 (51%)
Functionally improved	74 (45%)
Functionally same	3 (2%)
Functionally worse	
Functionally normal or improved then worse	4 (2%)

TABLE 6

CAUSE OF DEATH	NUMBER OF CASES
Cardiac	30
Cerebral	9
Malignancy	5
Renal	1
Pneumonia	1
Pulmonary embolism	2
Following other surgery	2
Gastrointestinal hemorrhage	1
Suicide	1
TOTAL DEATHS	52

Although this study and others have shown that carotid endarterectomy is effective in the prevention of recurrent stroke, the basic disease process of arteriosclerosis remains unaltered. It is, therefore, not surprising that there is no convincing evidence that carotid endarterectomy prolongs survival. The majority of late deaths following endarterectomy are caused by associated coronary arteriosclerosis.

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▶ Dr. Nunn, 2105 Park Street, Jacksonville 32204.

Editorial Comment by Fred Q. Vroom, M.D.

Dr. Nunn has proven it is possible to perform the arteriography and surgery with relative safety with improved technique. Unfortunately, no studies, including the joint study has shown an impressive difference in patients treated surgically versus medically. The reduction in transient ischemic attacks is modest. Prevention of stroke is not proven to be better than a medically treated control group and life span has not been shown to be lengthened.[1]

Unfortunately, the problem of patient selection persists. The natural history of transient ischemic attacks varies considerably with different series of patients, i.e., from 2 per cent to 51 per cent.[2] Certain symptoms such as vertigo, visual symptoms and drop attacks run a relatively benign course. When stroke does occur, it is often delayed in time and tends to be much less severe than those with symptoms in a carotid artery distribution (which can be extremely disabling because of language, intellectual and motor deficits). Additionally, these symptoms often are related to the basilar vertebral circulation and hence are not amenable to carotid artery surgery.[3] Finally, even some carotid syndromes, such as amaurosis fugax, run a relatively benign course with 84 percent not developing any deficit. Of those that do develop a deficit, 11 per cent develop only monocular blindness, 6 per cent develop hemiplegia, and only 1 per cent develop hemiplegia and monocular blindness.[4]

Because of variability in the natural history of different symptoms, it will be essential to have matched controls to prove the worth of any therapy in cerebrovascular disease. Hopefully, specific clinical syndromes will be defined in order to allow better patient selection for the various therapeutic measures available.

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Cancer of The Lip

Andrew W. Klein, M.D., Anthony M. Weikel, M.D., and Hal G. Bingham, M.D.

Abstract: Our experience with squamous cell carcinoma at the University of Florida Medical Center from 1962 to 1974 is presented. Mortality rates are in agreement with other reported series. Appropriate initial therapy is stressed to avoid recurrences and metastases with their unfavorable 5-year survival rates.

Carcinoma of the lip in the true form involves only to the limits of the vermilion border and is squamous in nature. Because of the confusion which exists in anatomically defining the lip from the remainder of the face, there is a tendency on the part of the clinician to lump carcinoma of the lip with other skin cancers. More correctly, it should be evaluated as an intraoral carcinoma whose treatment and prognosis differs from skin cancers. There are many papers in the literature on this particular carcinoma and our series is modest.[1-10] It is not the purpose of this paper to serve as an extensive review, rather as a reminder to the practicing surgeon that carcinoma of the lip is a serious malignancy with a significant rate of recurrence and mortality.

Characteristics and Etiology

Carcinoma of the lip accounts for about 1% of the malignant tumors occurring in the human body. It is chiefly a disease of light skinned males with the world literature mentioning ratios of 8:1 to 20:1 male over female. The disease is rarer in Blacks as are most skin cancers. Sun exposure has been correlated with climate and occupation with increased incidence seen in farmers, sailors, and fishermen.[11]

Smoking is thought to be etiologically important with particular reference to pipe smoking.[12] The single best evidence for the role of pipe smoking is a study by Ahlbom of Irish peasant women, Negro women and Swedish women who were pipe smokers.[13] They showed a markedly increased incidence of carcinoma of the lip. Concerning smoking in general, most series show approximately 80% of patients are smokers.

From the Division of Plastic and Reconstructive Surgery, University of Florida Medical Center, Gainesville.

Various chemicals have been related to lip carcinoma. Neglected oral hygiene and advanced development of precancerous lesions such as cheilitis, leukoplakia and cornium cutaneum are mentioned as etiological factors. Alcoholism is common in lip cancer patients with chronic users making up about one half the cases in most series.

Of special note, our series contains a case of xeroderma pigmentosa in an eight and one-half year old patient in whom lip cancer developed. This is the youngest patient we have found in our search of the literature.

Carcinoma of the lower lip is about ten times as common as carcinoma of the upper lip. Reasons generally given are the more exposed nature of the lower lip and its contact with irritants. Carcinoma of the upper lip carries a worse overall prognosis because of its varied lymphatic spread.

Cross et al studied commissure lesions and noted they carried a particularly poor prognosis.[14] They reported on 48 commissure cases with a 5-year survival rate of 35% which was correlated with an overall survival rate of all lip tumors of 80%.

For purposes of recording and staging of tumors, the TNM classification has been utilized. Lesions less than 2 cm. are T_1, those 2-4 cm. are T_2, and T_3 lesions are those greater than 4 cm. T_4 lesions are those greater than 4 cm. and involving contiguous structures. The N stands for "nodal involvement," with N_0 indicating no involvement, N_1 indicating unilateral nonfixed nodes, N_2 contralateral or bilateral nonfixed nodes and N_3 indicating any fixed nodes. The M_0 stands for no metastases while M_1 implies metastases to be present.

Results

Sixty-one cases from the University of Florida Medical Center were collected from 1962 to 1974. Of these patients, 52 were males and nine were females. Thirteen of the 61 cases were upper-lip carcinomas. The high incidence of upper-lip cancer is at variance with the literature we examined and probably reflects the fact that our institution is largely a referral center.

Seventeen patients had previous treatment at another institution prior to their referral; this consisted of surgery or radiotherapy. In some cases both modalities were employed, and two patients had received chemotherapy. Of these 17 referrals, 13 showed extension of disease beyond the local level. This compares to 14 patients who were initially treated at the University of Florida, demonstrating metastatic disease when first seen.

Six patients had recurrences after treatment was instituted here. Thirteen patients out of 17 initially treated elsewhere demonstrated recurrences after treatment.

There were 14 patients in our series whose death could be directly attributable to cancer of the lip (23%). This is a higher rate of mortality when compared with other series. Eleven of the 14 patients had received initial treatment elsewhere while the other three had been initially treated at our institution. These data are summarized in Figure 1 and compare referred cases to those initially treated at the University of Florida.

There were 27 patients with recurrent lip cancer in our series with a mortality of 52%. This figure for recurrent disease does not exceed the results of other series and points out the importance of initial adequate treatment.

Discussion

The results of the treatment of lip cancer at the University of Florida Medical Center do not differ markedly from the experience of most series in the literature. Our overall mortality was 23%. The sharp increase in mortality of 52% is directly related to spread of lip cancer in recurrent cases and argues very strongly for adequate initial therapy. Beckman et al urge frozen section analysis at initial removal to assure adequate margins.[15]

Taylor and Nathanson[16,17] have reported increased grading and size of initial lesions to be inversely proportional to 5-year survival rates; 50% metastases were reported in T_3 carcinoma (i.e., primary tumor larger than 4 cm.). An increase in lymph node size has been shown to harbor metastatic disease in 92% of cases where nodes were larger than 1-2 cm. Inadequately treated lesions have been shown to develop lymph node metastases two to three times more frequently than the primary. Cross et al had 5-year survival of 35.9% in patients with proven positive nodes. Jorgensen et al reported a 96.7% corrected 5-year survival using radium intubation in 869 patients but this figure dropped to 51% when neck nodes were present.[18]

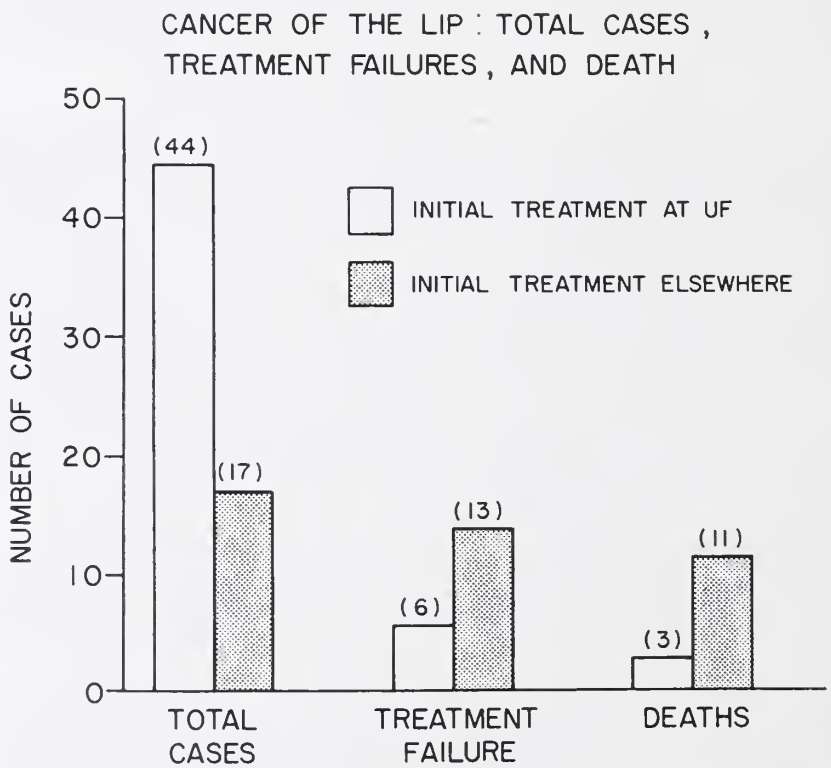

Figure 1

In cases where leukoplakia is also present a total vermilionectomy should be included with the wedge resection. Paletta has shown a 12% incidence of carcinoma in situ associated with leukoplakia of the lower lip.[19] The possibility of cranial nerve spread should be considered when diagnosing and following patients with lip cancer.[20] The location of the cancer will also alter 5-year survival figures and is most closely correlated with lymphatic drainage sites.[21]

Another important factor in evaluating therapy is that of the patient himself. Two patients in our series were untreatable due to advanced disease when initially examined.

In the management of cancer of the lip, the following recommendations are made: 1. Any lesion that persists more than two weeks should be suspected of being a malignancy and should be biopsied. Excisional biopsy is preferred. 2. Continued ulcerations and/or leukoplakia should have a vermilionectomy with microscopic analysis. The patient should be advised to protect the lips from further sun exposure and inhalation irritants. 3. Proven malignant lesions should be excised with adequate margins and frozen sections utilized in cases of doubtful margins. The submental and submaxillary nodes, along with the remaining neck nodes, should be carefully evaluated for metastatic disease. In the 10% to 15% of cases of metastatic node involvement, a standard radical neck dissection should be performed at the time of resection. Some authors prefer to delay the neck dissection, awaiting resolution of possible inflammatory nodes. Reconstruction of the lip defect should be accomplished at the time of removal. 5. When the tumor has spread beyond the confines of the lip to involve alveolus or other intraoral structures, these latter should be included with the resected specimen. 6. If one is dealing with spindle-cell highly undifferentiated carcinoma, a careful search for perineural invasion is suggested and should, preferably, include mental nerve biopsy at the time of surgery. If mental nerve involvement is noted, then resection of the mandibular segment is indicated. 7. Consultation with a radiotherapist is indicated for T_3 and T_4 lesions or those with metastases so that a combined approach may be planned. Whether radiation is given pre- or postoperatively will depend on the training or preference of the physicians involved. T_1 and T_2 lesions can be treated equally well by excision or radiation therapy.

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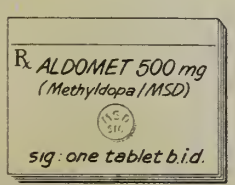

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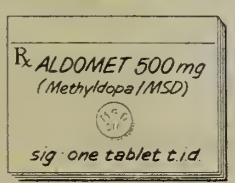

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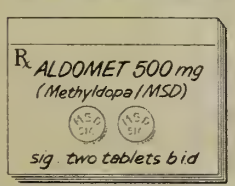

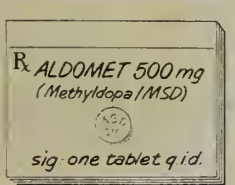

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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MSD MERCK SHARP & DOHME

Others Are Saying

There is no group of patients so neglected with regard to their rehabilitation needs as cancer patients. There is a lack of understanding on the part of most of the medical profession as to what rehabilitation medicine really is. They tend to equate this specialty with physical medicine and do not recognize the psychological, social and vocational benefits that this specialty can extend to their patients.

Our medical curriculum is oriented toward acute medical care. Students get little if any exposure to rehabilitation medicine, and cancer is taught in such a fragmented manner, that a conceptual understanding of the overall needs of cancer care is rarely obtained. In the past, even the rehabilitation specialists were not willing to accept the cancer patient. They regarded these patients as not having rehabilitation potential, a carryover of the fatalistic attitude toward cancer. Even clinical oncologists within the categorical cancer institutes gave little concern in the past to the rehabilitation of the patient with cancer. The prime concern was to increase the quantity of survival. Now that an increase in survival has developed we must look at not only how many survive but how they survive.

During the past few years there has been an awakening toward the realization of the rehabilitation needs of the cancer patient. Several major events were significant in this change of philosophy: the action of the Social and Rehabilitative Services of the Department of Health, Education and Welfare; the action of the American Cancer Society which chartered one of their major committees as the Service and Rehabilitation Committee; and the National Cancer Act of 1971 which put forth seven major objectives in the National Cancer Program, objective 7 being to develop the means to improve the rehabilitation of the cancer patient.

Cancer patients should be given the same rehabilitation opportunities as those given to patients afflicted by other chronic diseases in order that they may return to their families, their communities and their vocations with dignity rather than despair. — John E. Nealey Jr., M.D., Professor of Orthopaedic and Rehabilitation, University of Miami School of Medicine, Miami, in *Miami Medicine*.

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Special Article

Florida's Regional Neonatal Intensive Care Program—Impact on Mental Retardation

Edmund A. Egan, M.D., Richard J. Boothby, M.D. and
E. Charlton Prather, M.D.

Florida's Regional Neonatal Intensive Care Program originally received funding from the Florida Legislature in 1974. Our FMA Treasurer, the Honorable Richard S. Hodes, provided the initial legislative thrust for this program. Senator Kenneth Plante and Representative John Considine have joined with Dr. Hodes in actively supporting expansion of this program.

The AMA Committee on Maternal and Child Care has recently called for the establishment of state committees for high risk maternal and newborn care. One of the authors of the following article, Dr. Richard Boothby, has successfully chaired such a committee, the Florida Perinatal Care Program, for over three years.

Authorship of the following article reflects the effective relationship among physicians working in state government, those involved in the leadership of professional committees, and those giving patient care. Such dovetailing of resources has characterized Florida's Perinatal Care Program from its inception. The results detailed in the report offer new hope for the prevention of mental deficiency. It is an important article for every physician involved in maternal and child health care, and indeed for all parents. — The Editor.

The child who has mental retardation, or mental deficiency, has impairment of the most complex human functions. Other chronic disabilities in patients with intact intellect offer the chance for using the flexibility and adaptiveness of the brain in helping to minimize the effect of the disability at a personal, family, and community level. The disabled patient, with severely limited intellectual capacity as a primary component of his disability, has little potential to be a personally or socially independent individual. Such patients place a major burden on their families and communities; and they also have great difficulty in achieving minimal personal contentment for themselves.

Mental retardation has been estimated by two methods to affect approximately three percent of the population of children.[1] One method has been to regard all individuals who score less than two standard deviations (30 points) below the mean of 100 on standard IQ testing, as significantly intellectually impaired. The second method has been clinical evaluation of the population in specific areas, which has yielded similar results to the mathematical estimate.[2]

Dr. Egan is Consultant to the Division of Children's Medical Services; Dr. Boothby is Chairman of the Fetus and Newborn Committee of the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics and Pediatric Co-Director of Florida's Perinatal Program. Dr. Prather is Staff Director, Health Program Office, Department of HRS, Tallahassee and Associate Editor of the Journal of the Florida Medical Association.

However, it has been recently discovered that about two-thirds of this mentally retarded group disappear after adolescence and do not form a recognizable segment of the adult community.[3] These mobile individuals are termed educationally mentally retarded and many apparently merge into the general adult population to lead rather independent and functional lives. However, approximately one percent of children are so impaired that they remain permanently as dependent members of the community. Florida's Division of Retardation identifies over 50,000 such individuals in Florida.[4]

Perinatal Factors and Mental Deficiency

Analyses of the etiologic factors responsible for severe mental deficiency (IQ less than 50) are available for institutional[5] and geographic[7] populations. Such reports are limited by their use of information from incomplete and often second hand medical histories and physical examinations. As seen in Table I, 43-65 percent of the patients have an unknown etiology. This group has been labeled in the past as idiopathic, described according to their clinical status on examination (microcephaly, cerebral palsy, etc.), or unscientifically placed into such categories as environmental mental retardation.

Table 1.—Etiology of Severe Mental Retardation in an Institution and a Geographic Area
(Calculated from Pitt and Roboz[5] and from McDonald[6])

	Institution Population	Provincial Population
Chromosomal abnormalities (mongolism and others)	18%	23%
Other syndromes, congenital anomalies, and genetic diseases	32%	5%
Post-natal injury, congenital and acquired infections	7%	9%
Total known:	57%	35%
Total unknown:	43%	65%

In the 1960s prospective studies of infants revealed that a high proportion of prematures who survived suffered from severe central nervous system impairment. In Table 2 calculations from the population of children who were premature, taken together with the established rates of impairment in such children, show that perinatally damaged premature infants will account for an incidence of severe impairment in the total childhood population of 0.5 percent. Full term infants also suffered at least a 0.5 percent incidence of perinatal damage, both from prospective studies[8] or by calculations from independent analyses made of asphyxia,[9] hypoglycemia,[10] and obstetric complications.[11] Each are major sources of perinatal danger for full term infants.

It seems clear that perinatal events, acting on previously normal fetuses, produce fully one percent of surviving children with severe impairment. In the 1960s the high death rate of this group in childhood[12] may account for the fact that the total incidence of severe impairment in the age group 0-20 is only one percent. The conclusion seems inescapable that the large "unknown" group in studies on mentally deficient populations is largely identical to perinatally acquired mental deficiency in the prospective group. Indeed, a 1973 analysis of institutionalized patients in Arizona has reported 43 percent of the mentally deficient suffer from perinatally acquired defects.[13]

Florida's Regional Neonatal Intensive Care Program

In 1971 it was reported that very small prematures (less than 1500 gm birth weight), cared for in a neonatal intensive care unit, showed only a 10 percent incidence of impairment,[14] rather than the previously reported 50 percent.[15,16] Such a finding has been confirmed from other centers.[17] These data, documenting the social benefit available from perinatal care, generated the creation of an organization now known as the Florida Perinatal Intensive Care Program in 1972. It is a joint effort of the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society, the Florida Society of Obstetrics and Gynecology. The program has worked with the Department of Health and Rehabilitative Services, particularly the Division of Children's Medical Services and the Division of Health, and had financial support from Florida's Regional Medical Program. Leadership for this statewide effort to improve all aspects of perinatal care is continuing under the co-directorship of Dr. Richard Boothby of Jacksonville and Dr. James Werba of Orlando.

In 1974 the efforts of the Perinatal Program were rewarded by the initiation of the Florida Regional Neonatal Intensive Care Centers (RNICC) by the Division of Children's Medical Services of the Florida Department of Health and Rehabilitative Services. It started with five centers as regional neonatal intensive care units: Sacred Heart Hospital in Pensacola, University Hospital in Jacksonville, Shands Teaching Hospital in Gainesville, Tampa General Hospital in Tampa, and Jackson Memorial Hospital in Miami. Further expansion is planned for additional cen-

Table 2.—Prematurity, Mental Deficiency, and the Childhood Population
(Calculated from Chase[7] and from Drillin[8])

	Very Small Prematures (< 3½ lbs birth weight)	Other Prematures (3½ – 5½ lbs birth weight)
Percent of live births in United States in 1960's	1.6%	6.9%
Percent of survivors of infancy	0.4%	6.0%
Rate of severe mental impairment	50.0%	5.0%
Percent of entire child population, impaired, born in weight group	0.2%	0.3%

ters as soon as possible to complete the need for such centers in central and south Florida.

Such Regional Neonatal Intensive Care Centers are located in hospitals with full obstetric capability. Each RNICC is directed by a full time neonatologist, a pediatrician with two years subspecialty training or the equivalent in neonatal-medicine, whose practice is limited to the RNICC unit. Each center has a fully equipped neonatal intensive care unit and a transport system for moving infants born in other hospitals who need such neonatal intensive care.

In 1974, 14,000 children were born in these five hosptials, approximately 13 percent of the children born in the State of Florida. Of these 14,000 infants, 11 percent were admitted to the special care unit at each hospital. In addition, 990 infants were referred from the hospital of their birth to one of the neonatal intensive care units. These 990 infants represent about one percent of Florida's babies born outside the RNICC hospitals.

An integral part of the RNICC program is the post discharge evaluation of survivors. *All* infants under 1500 gm birth weight are entered into the evaluation program, which documents their physical and mental development after discharge. A random sample of 20 percent of infants over 1500 gm birth weight is also followed in serial fashion. These children are evaluated both by a pediatrician and by a pediatric neurologist or psychologist. *All* children in the evaluation program are examined at age six months, one year, two years, four years, and six years. The dates of evaluations are adjusted for prematurity in the first two evaluations, so that the survivors who were born premature are measured against scales for cohorts conceived at the same time, rather than those born at the same time.

Evaluation Results for First Year

The evaluation program for 1974-1975 is detailed in Table 3. As can be seen, there was 85 percent success in achieving follow-up of the identified patients. Presently the numbers are small, because only the patients discharged in the second half of 1974 were at the age for evaluation prior to the tabulation of the results on July 1, 1975. The evaluation data is seen in Table 4. It shows that over 90 percent of both groups of patients are judged normal by the evaluation teams. The higher percentage of abnormals in the group over 1500 gm, reflects the fact that only sick infants in this group are admitted or referred to an RNICC. The sophistication of the testing methods of these young children are still imprecise, since most of the neurologic and developmental features concern motor and not intellectual function. We are encouraged, however, that the under 1500 gm birth weight infants at this early stage are showing an almost identical evaluation result to the largest single center long-term follow-up of such infants receiving intensive care.[14] We feel that this lends credence to the hypothesis that over 90 percent of these infants will continue to be measured normal as their evaluation progresses. Indeed, longitudinal programs may tend to overestimate impairment in the early evaluations.[8]

The importance for the State of Florida can be estimated by comparing the results of the RNICC infants in 1974-75 to what one would have expected for the same group of infants in the 1960s. Table 5 details such a calculation. The impact on mental retardation is real. The 55 per-

Table 3.—Florida's Regional Neonatal Intensive Care Center Evaluation Program, 1974-1975

	Birth Weight < 1500 grams	Birth Weight > 1500 grams
Number for evaluation	112	159
Number evaluated	95	135
Percent evaluated	85%	85%

Table 4.—Results of Florida's Regional Neonatal Intensive Care Center Evaluation Program, 1974-1975

	Birth Weight < 1500 grams	Birth Weight > 1500 grams
Number evaluated	95	135
Number judged normal	88	123
Number judged abnormal	7	12
Percent abnormal	7%	9%
Percent normal	93%	91%

Evaluation data shown in this table is a statewide joint effort of the following Regional Neonatal Intensive Care Centers

1) Sacred Heart Children's Hospital, Pensacola
   Edward R. Westmark, M.D., Director, RNICC
2) University Hospital, Jacksonville
   R. Donald Garrison, M.D., Director, RNICC
3) Shands Teaching Hospital, Gainesville
   Donald V. Eitzman, M.D., Director, RNICC
4) Tampa General Hospital, Tampa
   John S. Curran, M.D., Director, RNICC
5) Jackson Memorial Hospital, Miami
   Eduardo Bancalari, M.D., Director, RNICC

TABLE 5.—ESTIMATION OF IMPACT OF FLORIDA'S REGIONAL NEONATAL INTENSIVE CARE CENTER PROGRAM ON MENTAL DEFICIENCY, 1974-1975

BIRTH POPULATION ESTIMATED AS 16,900*
BASED ON EXTRAPOLATION OF DATA IN TABLES 2 AND 4 TO ESTIMATED POPULATION

	Expected Pre-RNICC				RNICC Program			
	Survivors	×	Impairment Rate	= Number Impaired	Survivors	×	Impairment Rate	= Number Impaired
1500 grams	59		50.0%	30	112		7%	8
1500-2500 grams	943		5.0%	47	983		3%	30
>2500 grams	15,470		0.5%	77	15,516		0.2%	31
				154				69
Number in which impairment Prevented = 85					Percent Reduction = 55%			

*Population = inborn infants at RNICC hospitals + referral population = 16,900 referral population = total births for a population which referred 445 infants in last six months of 1974, and in whom these 445 infants were the 5% of the population requiring neonatal intensive care (445/.05 = 8,900)

cent decrease has the potential for a dramatic change in the incidence of severe mental deficiency.

Discussion

Florida's Regional Neonatal Intensive Care Program is unique in these United States. It is the only statewide program which has committed itself to measuring its effectiveness both in terms of survival and the quality of the lives of its survivors. Further, the RNICC program seeks to utilize the resources of medical care already functioning in the state, and to encourage each of the Centers to develop its own unique methods to meet the local need of mothers and children. Furthermore, the RNICC program has developed simple and objective criteria regarding the quality of care expected from such a Regional Neonatal Intensive Care Unit. This will enable the program, operating as a statewide entity, to insure every area of Florida is being served by an effective regional perinatal-neonatal unit.

In an era of awakening public interest and concern for the rights of retarded citizens, it appears crucial that the access to medical care capable of preventing mental deficiency be recognized. No other group of individuals, by reason of their number and needs, place a greater strain on the personal and the economic resources of Florida's citizens.

This preliminary report should be considered as just that—preliminary. Perinatal medicine has had more clinical advances in the last 10 years than in the preceding 50. *If presently available standards of perinatal care are made accessible to every pregnant woman and her infant, mental deficiency could be lowered by at least one-third.* Newly emerging advances in medical management of gestation, parturition, and the neonatal period offer the hope that perinatal causes of mental deficiency will be as rare in the future as post-measles encephalopathy is today.

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Special Guest Editorial

Mental Retardation

Let's begin at the beginning.

Mental retardation is a manifestation of disease; the process leading to impaired mental development generally occurs before birth, during birth or shortly thereafter (though brain damage can occur at any time in one's life and result in a mentally handicapped condition).

The scope of the problem is vast, both in Florida, the nation, and indeed, in the world.

There are approximately six million retarded people in the United States; 126,000 babies are born retarded each year—that's one every five minutes. In Florida alone (three percent of our 8.5 million population figures) there are over 200,000 retarded citizens, and there will be more by the time you finish reading this.

Before you decide it could never happen to you or anyone you know, let me remind you chances of having a retarded child are three out of a hundred . . . somebody has to be counted one, two, three . . . and the saddest part of the retardation story is that we can do something about it, or more correctly, we could do something about it with the right help and funding.

If we could just apply what we know about retardation today we could cut by 50 percent the number of retarded babies born in the next year.

Malnutrition and poverty combine to form one of the major causes of retardation:

* Proper nutrition in poverty areas could prevent millions of cases of retardation,
* Better prenatal care could cut the number of retarded babies even more,
* Proper care at birth could take another swipe at the number of children who are destined to a life of retarded development, and
* Education, to prevent the thousands of cases of lead poisoning each year, would also help.

It's not that it would take so much from any one of us, it's simply that we all must be willing to give.

Retardation is everybody's business. If you and your family have been spared the heartache of knowing retardation personally, don't assume you always will be spared. Remember, our people range from infancy to grandparenthood.

In Florida we have problems and we know it . . . our institutions are understaffed, underfinanced and overcrowded. We suffer from chronic problems of fire safety, poor health facilities and lack of programs (training situations).

We talk in terms such as normalization, developmental training, regionalization, deinstitutionalization, citizens advocacy and reorganization. Our conversation is peppered with words like educable, trainable and severely and profoundly or synonymous terms like mildly retarded, moderately retarded, severe and profoundly retarded, not to mention that old "stand-by" borderline.

But in Florida we have some good things going for us, too. Perhaps the best thing is the Bill of Rights of Retarded Persons, as passed by the past legislative session and signed into law by Governor Askew on June 29th. This piece of landmark legislation puts us out in front of every other state in our show of concern for our retarded citizens. The Bill guarantees our retarded citizens 13 inalienable rights:

Mr. Kelley is Director, Division of Retardation, Tallahassee.

* The right to dignity, privacy and humane care

* The right to religious freedom and practice

* The unrestricted right to communication

* The right to personal possessions and effects

* The right to education and training

* The right to prompt and appropriate medical care and treatment

* The right to social interaction

* The right to physical exercise

* The right to human discipline

* The right to physical examination prior to subjection to a treatment program to eliminate bizarre or unusual behaviors

* The right to minimum wage protection and fair compensation

* The right to be free from physical restraint, and

* The right to a central record.

Don't misunderstand, the Bill of Rights of Retarded Persons is not the end-all, but it is the dawn of a day of awakening for our retarded citizens. The Bill of Rights will not eradicate the problems of mental retardation, but it is a new hope for the retarded citizen. Hopefully, the next five years will bring us the quality of care and training, both in the institution and in the community, for which we all strive — if we get that funding and support of which we spoke earlier.

As professionals in the field of developmental disabilities, we think it ironic a law must be passed to enable us to do the things we KNOW are right, but the fact remains — and it is a national indictment, an indictment that is now being answered in Florida, with the passage of the Bill of Rights. If during this, National Mental Retardation Month, we can take one step farther along the road to answering that indictment we will be able to call ourselves successes.

FRANCIS P. KELLEY
TALLAHASSEE

Mental Retardation

it shouldn't be ignored!

For many years it was. During the past 25 years, a strategic course devoted to ensuring mentally retarded children and adults equal human rights and services has been pursued by the National Association for Retarded Citizens.

PKU screening, infant care training, preschool programs, special education classes, vocational counseling and on-the-job training for mentally retarded individuals exist today because of the efforts of more than a quarter of a million volunteers.

Research into the causes and elimination of preventable cases of mental retardation are also goals of the more than 1700 state and local units. Lead poisoning, malnutrition and improper prenatal care have been singled out as contributing factors to mental retardation. Using the knowledge we now have, approximately one-half of the new incidents of mental retardation each year are preventable.

Our attitude about mentally retarded people has changed too. We've learned what others already knew — that given a chance mentally retarded citizens can lead productive lives and contribute substantially to their communities.

The labor has been painstaking. The results are worth the commitment.

The National Association for Retarded Citizens observing its 25th anniversary.

National Association for Retarded Citizens
Silver Anniversary
1950-1975

For information, write:
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Special Article

Rheumatic Fever Programs in Florida: Update

Elia M. Ayoub, M.D., Marshall E. Groover, M.D., Robert E. Windom, M.D. and Sidney Blumenthal, M.D.

Every year, throughout the State of Florida, patients continue to be seen with acute rheumatic fever and rheumatic heart disease, or with recurrences of their disease. This occurs, despite the fact that these attacks are preventable. Two years ago the Florida Task Force on Rheumatic Fever was organized. This Task Force, which is comprised of three representatives each from the Florida Medical Association, the Florida Heart Association, and the Department of Health and Rehabilitative Services, was charged with the reevaluation of the extent of the rheumatic fever problem in Florida and with the updating of existing programs for the control and prevention of this disease. The efforts of the Task Force to date, with additional support from the Florida Heart Association and the Florida Regional Medical Program, have brought about an increased awareness of this medical problem in the community and the establishment of additional services to physicians in the diagnosis and treatment of rheumatic fever. These efforts represent a step forward but are still short of the ultimate goals of this program. What can the medical community do in furthering the efforts of the Task Force?

The prevention of initial attacks of rheumatic fever still remains a frustrating problem. Theoretical and practical factors contribute to the difficulties in designing an effective primary prevention program. These factors include the occurrence of subclinical streptococcal pharyngitis, the inaccessibility to adequate medical care for all echelons of the population and the absence of mechanisms that allow the identification of individuals, particularly children, susceptible to this complication prior to the initial attack of rheumatic fever. Because of this, efforts have been directed at the prevention of recurrences in *known susceptibles,* namely, those individuals who already have had an initial attack and who are at high risk of recurrent attacks following streptococcal pharyngitis. To this end, the Division of Health has established a program for providing FREE prophylaxis to prevent streptococcal infections. How can the physician make this prophylaxis available to his patients?

To obtain prophylaxis, the following steps should be followed:

1. All newly diagnosed patients, and those previously unregistered, should be enrolled in the Rheumatic Fever Registry of the State Division of Health. This requires completion of Form DHRS.CD 1-July•75 RFTF 2000, which is available at your local County Health Department. Completion of this form will help place the patient's name on the registry, but it does *not* automatically imply that the patient will receive prophylaxis from the State. If the physician or patient prefers, he may purchase the antibiotics and have these administered in his physician's office.

2. Free prophylaxis is made available by the State to any individual with rheumatic fever, with or without heart disease. To make this available to his patients, the physician should complete Form DHRS.CD 6-26•75, supplied by the State Division of Health through the County Health Department. In this form the physician should specify the preferred method of prophylaxis. Completion of this form would make the patient eligible for lifetime prophylaxis if desired.

More important, however, is the assurance that prophylaxis is being taken. Although we could delegate this responsibility to the patient, it behooves the physician not to discharge himself completely of this obligation. This can be achieved by following the patient in the clinic.

Dr. Blumenthal is Chairman, Florida Task Force on Rheumatic Fever; Dr. Windom is Vice Chairman, and Drs. Ayoub and Groover are members of this committee.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
HEART DISEASE CONTROL PROGRAM
Post Office Box 210 Jacksonville, Florida 32201

RHEUMATIC FEVER REGISTER

Patient's Name			Address (Street & City)	Date of This Report
Birthdate	Sex	Race	Birthplace	Length Residence in Fla.
Date First Seen By Me		Present Rheumatic Activity Status ☐ Active ☐ Inactive		Date of First Attack
Place of First Attack			Diagnosing Physician, Hospital, or Institution	

Jones Criteria Used in Diagnosing Rheumatic Fever:

MAJOR
- ☐ Carditis
- ☐ Polyarthritis
- ☐ Chorea
- ☐ Subcutaneous Nodules
- ☐ Erythema Marginatum

MINOR

Clinical
- ☐ Fever
- ☐ Arthralgia
- ☐ Previous Rheumatic Fever or Rheumatic Heart Disease

Laboratory
- ☐ Acute Phase Reactants
  - ☐ increased sed rate
  - ☐ positive C-Reactive protein
  - ☐ leukocytosis
- ☐ Prolonged P-R Interval

Evidence of Preceding Streptococcal Infection
- ☐ Throat culture positive for group A beta streptococcus
- ☐ Recent scarlet fever
- ☐ Elevated streptococcal anti-bodies (ASO, anti-BNAse B, Streptozyme, etc.)

SUBSEQUENT RHEUMATIC FEVER ATTACK

	Date	Place of Occurrence	Physician	Manifestations, Therapy, Etc.
1.				
2.				

RHEUMATIC HEART DISEASE? ☐ No ☐ Yes (Check Manifestation Present)

Anatomic Class
- ☐ M.I. ☐ M.S.
- ☐ A.I. ☐ A.S.
- ☐ Cardiomegaly
- ☐ Other

Physiologic Class
- ☐ Normal Rhythm
- ☐ Arrhythmia
- ☐ Heart Failure

Functional Class
- ☐ Class I ☐ Class II
- ☐ Class III ☐ Class IV

Therapeutic Class
- ☐ Class A ☐ Class B
- ☐ Class C ☐ Class D
- ☐ Class E

(See Back of Page)

In my opinion, the diagnosis of acute rheumatic fever in this patient is:

Certain, because:
- ☐ Patient has 2 major criteria plus evidence of preceding streptococcal infection
  or
- ☐ Patient has 1 major plus 2 minor criteria plus evidence of preceding streptococcal infection

Possible, because
- ☐ Major criterion is not definite
- ☐ No evidence of previous streptococcal infection
- ☐ Patient has chronic, not acute disease
  - _____ Heart murmur
  - _____ Chronic arthritis
- ☐ Other

Would you like to review this case with a consultant?
☐ Yes ☐ No

PREVIOUS RHEUMATIC PROPHYLAXIS
☐ Yes ☐ No

Is patient allergic to penicillin?
☐ Yes ☐ No

Form	Dates
☐ Oral Pen. -	
☐ I.M. L.A. Bicillin	
☐ Oral Sulfa-	
☐ Other (specify)	

Physician's Name

Physician's Address

DHRS/CD/1/July/75 RFTF 2000

APPLICATION FOR PROPHYLACTIC MEDICATION
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
BUREAU OF ADULT HEALTH AND CHRONIC DISEASES

Patient's Name (Typed)_____Race _____Age_____Sex_____

Address (Typed) _____County _____

The above named patient has had rheumatic fever and should be on prophylactic drugs to prevent secondary attacks. The Department of Health and Rehabilitative Services is requested to furnish the following drugs at no cost to the patient.

Check desired medication:

1. Sulfadiazine 0.5 Gm. twice daily by mouth — 200 Tablets ( )
2. Penicillin G Tablets (Bicillin) 200,000 units twice daily by mouth — 180 Tablets ( )
3. Benzathine Penicillin G (Bicillin) Long Acting 1,200,000 units by injection once monthly — 5 Tubex ( )
4. Erythromycin, 250 mg. twice daily by mouth — 200 Tablets ( )

Signature _____M.D.

Signature typed _____M.D.

Address _____

_____

DHRS/AH/6/25/75/1500

Tests for the presence of penicillin or sulfa in the urine are available (free) at the State Health Laboratory. This will help check if prophylaxis is being adhered to, particularly if the patient is taking oral antibiotics. Those patients who will not be followed by their physicians should be referred to State Health agencies or State sponsored Rheumatic Fever Clinics where the follow-up program includes supervision of adequate prophylaxis.

To reiterate, the most important phase of the care of rheumatic patients *starts* with the diagnosis and treatment of the first acute episode and *continues* with the provision of continuous prophylaxis against recurrences. While it is the choice of the involved physician as to where this care is given, it is an implicit obligation to see that such care is provided. Without continuous prophylaxis, the patient remains at an extremely high risk of recurrences and with each recurrent attack the hazard of more severe and permanent cardiac damage.

▶ Dr. Ayoub, Department of Pediatrics, University of Florida College of Medicine, Gainesville 32610.

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Editorials

The Medical Malpractice Reform Act of 1975

The Florida Legislature's response to the malpractice crisis is now law.[1] The top of the crisis has been incredibly accelerating insurance premiums crammed down physician throats with the lever of a threat of withdrawal of insurance support. Now, at least, insurance of some kind will remain available through the mechanism of the Joint Underwriters' Association, but the predicted premiums might even turn the golden fleece of Argonaut green with envy. Apparently the only viable way to level the top of the crisis is self insurance through the FMA or other groupings. Maybe the study commission created by the Medical Malpractice Reform Act of 1975 will provide an unlikely miracle. How many medical stomachs could accept a suggestion of state managed if not subsidized medical insurance?

The crisis has deeper levels than insurance. The trauma of litigation and its threat to reputation cannot be insured. Litigation costs, including excessive contingent fees and indirectly defensive medicine, inevitably swell health care costs. If there are solutions to such problems, they are not likely in crisis atmosphere. It is doubtful that the comparatively weak measures of the Reform Act will much slow the tide of verdicts and settlements.

A screening sort of mediation is now required, but a claimant is free to litigate even if the physician, judge, lawyer panel find against him. That finding will be heard by the jury. Frivolous claims, rarities really, will be weeded out, but at the cost of strengthening others in the rehearsal opportunity the panel process provides. No move was made to limit liability, a step of questionable constitutionality anyway. Lawyers' contingent fee schedules were not touched, however, the publicity strategy was weakened. Until constitutional test, the *ad damnum* clause is barred in malpractice petitions, so that dramatic amounts, usually much inflated, may not be stated there to attract the media. The claims are apt to have boiled to reality by the time of trial.

Probably most physicians will approve the Legislature's broadening of policing powers and duties within the medical societies and hospitals; however, the profession should be aware that such powers and duties provide the possibility of an added base for liability, albeit not against physicians as such but against hospitals. A significant precedent was placed in the wings from Illinois by the famous Darling Case.[2] There it was held that a hospital might be liable for failure to exercise adequate controls over physicians and nurses to prevent negligent treatment of a patient. The Florida courts had as yet done little to move in that direction, but the light is brighter green now.

The Reform Act encourages review of physician practices and in some situations requires it, as with the internal risk management program mandated for hospitals with more than 300 beds. Also, discipline reports must flow from medical societies, PSRO's, hospitals, and medical staffs —to the Florida Board of Medical Examiners. If taken seriously, and Darling is not for laughs, such moves should cut down not only on incompetence but also on bits of negligence which sometimes have grievous consequences for both patients and physicians. Yet, if taken too seriously, as is possible when zeal becomes misguided, then physicians' rights can be trampled. Physicians and administrators in review positions need to study due process requirements and its spirit as well, lest we see an even sharper upswing in *physician* initiated litigation.

The other swipe at the crisis was against the law of malpractice itself. The statute of limitations was amended but in possibly unconstitutional fashion. Previously, for instance, if some foreign item was left within the patient following surgery, the two year span for bringing suit ran from the time of actual discovery or when the patient reasonably should have discovered the problem. Now it is at a maximum four years from the date the item was thus mislaid, *even if not discoverable* within that period. The statute cuts off only part of the "long tail" which insurance companies have claimed as a cause of giant reserves and premiums. Some "long tail" situations may not be affected at all, for instance, those involving misdiagnosis in a continuing physician-patient relationship.

The second attempt to reduce the base of malpractice claims provides that physicians cannot be held for "any guarantee, warranty, or assurance" as to the results of treatment unless it is in writing and signed by the doctor. This does block an avenue for increased litigation which has as yet been little travelled in Florida. The good of the attempt is to reduce the slight risk that physicians will be held to guarantee from mere assurances of confidence and hope. One increase of risk is that a few physicians may be abetted in the over-merchandising of unneeded or harmful treatments. Still, such provisions are not enforced in the face of fraud, and courts have ways of broadening definitions of fraud when needed.

The amendment most difficult to assess is that styled as the Florida Medical Consent Law. At stake is the question when and to what extent must physicians discuss risks incident to treatment. The amendment in one move seems clearly enough to say that local medical custom will control, particularly if the treating physician has consent in writing. Yet in another move, loopholes seem to have been fashioned for plaintiffs' lawyers seeking to override medical judgment. Such is the way when a legislature attempts, especially in crisis, to work with scissors and paste at the fabric of common law which courts have been weaving through a period of some years.

The best advice from here seems still for physicians to make a sincere effort to encourage patients to make the important decisions with the fullest information possible under the circumstances. Make use of consent forms. Where discussions of risks seem medically contraindicated: seek consultation; discuss fully with the closer relatives; and keep complete records. The best defense against a malpractice claim remains a serious and manifested concern for the patient as a human being.

References

1. Chapter 75-9, Florida Session Laws.
2. Darling v. Charleston Community Memorial Hospital, 33 Ill. 326, 211 N.E. 2d 253 (1965).

WALTER PROBERT, J.D., J.S.D.
GAINESVILLE

Dr. Probert, Professor of Law and Medicine, University of Florida, Gainesville 32601.

Scientific Exhibit Applications Invited

The Committee on Continuing Medical Education is still accepting applications for scientific exhibit space at the 102nd Annual Meeting of the Florida Medical Association at the Diplomat Hotel in Hollywood in May, 1976.

Deadline for receipt of applications is January 1, 1976, according to E. Eddy Burns, M.D., Exhibit Chairman. Application forms may be obtained by writing to Dr. Burns, Florida Medical Association, P.O. Box 2411, Jacksonville 32203.

Installation of exhibits may begin at noon, Wednesday, May 5. They are to be ready for showing at 8:30 the following morning. Dismantling may not begin before 3:00 p.m. on Saturday, May 8.

The Malpractice Claim

Once a malpractice suit is filed against the physician, it is too late to make amends with the aggrieved patient and his family, too late for the physician to change his demeanor and mannerisms, and to improve the quality of his medical records. Immediate losses include his ego, time away from practice, and out-of-pocket funds. Additionally, he may have insurance problems, experience unpleasant publicity and possible physical hurt, and he is likely to have fewer patients and more sleepless nights. No matter what develops, he is headed for trouble.

In the unfortunate event of this happening to you, you may be wondering: Is it possible to reduce the losses and have the satisfaction of winning the case?

Here are some suggestions. Consider them objectively.

Duplicate *all* records pertaining to the case and return the original copies to their normal locations. This duplicated material should be legible. Include letters to and from the patient or his family, and to and from other physicians; office and hospital records, and any other written information pertaining to the patient. The records must not be altered in any manner.

Study possible areas of departure from "standard care," "informed consent," and other questionable action or lack of action.

Review the pertinent medical literature. Are other physicians conducting the same methods of treatment? Are there legitimate differences of opinion? Get as many references as possible to support the course which was followed with the patient.

Cover thoroughly all phases of the complaint in conferences with the insurance company attorney and your attorney. Both attorneys should be involved in consultations. Their relationship should be analogous to that of the surgeon and family physician in care of the surgical patient. The attorney representing the insurance carrier has the legal, ethical and moral duty to represent you as well as the carrier. Discuss this with him if there appears to be any question of his loyalty.

Insist upon the opinion of an experienced medical "expert" who is willing to review the circumstances. Assist your attorney in obtaining his services but avoid contacting potential expert witnesses directly without first consulting with your attorney. Effectiveness of the witness is sometimes enhanced if he has not conferred with the defendant about the case.

The expert witness should be well qualified and articulate with a modicum of histrionic ability. He may not be necessarily or even advisedly a professional expert, but one who will take a firm position and believe in it. In the event the "expert" cannot appear, determine his reasons from the attorneys and if they are not totally compelling, seek another one who can assist and also appear at the trial, if necessary. Most medical activities are sufficiently variable to satisfy some approved standards.

The deposition is critical. Answers to questions from uniformly aggressive, well-schooled attorneys must be considered and consistent. No quick replies, no hemming and hawing, or talking down to the plaintiff's attorney. Your attorney will be present to object to improper questions but discrepancies between the deposition and records when later compared with statements at the trial will surely be noted and can be devastating. Also the deposition can be read to the jury at the trial in lieu of your own testimony.

The plaintiff's attorney usually will be agreeable to settlement most of the time, if the price is right. The policy regarding settlement varies with attorneys' considered opinions as well as the views of claims managers and the claims policy of the insurance companies. Some company attorneys, of course, are more inclined to settle than others. Settlement is essentially nolo contendere, at least something comparable, and may appear to be an easy way out. It should not be accepted without serious thought, advice from your attorney and colleagues who have had similar experience; also your conscience, and your wife.

If you elect to go to trial, spend the necessary time to review past events in detail, become familiar with references, and obtain as much information as you can by talking with experts in the field. At the trial dress conservatively, look directly at the judge and jury, be yourself, listen carefully to questions, answer them deliberately and with assurance. Do not engage in vituperation or wisecracks. Avoid arguments and overly erudite replies. Be sorry the unfortunate event has occurred, but not apologetic.

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DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Not intended for sublingual use. Supplied in bottles of 30, 100 and 500 ISO-BID capsules.

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INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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Thiamine mononitrate (Vit. B_1)	25.0 mg
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Niacinamide	100.0 mg
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg.
Ascorbic acid (Vit. C) as sodium ascorbate	500.0 mg
Cyanocobalamin (Vit. B_{12})	5.0 mcg.

Each tablet contains 0.15 mg. saccharin as sodium saccharin

Each tablet provides the following multiples of the recognized adult minimum daily requirements:

Thiamine mononitrate	25
Riboflavin	10
Niacinamide	10
Ascorbic acid	16

The need for pyridoxine hydrochloride, calcium pantothenate, and cyanocobalamin in human nutrition has not been established.

USUAL DOSAGE: *Adults* – 1 tablet daily, or as directed.

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Desiccated animal gland thyroid products can vary in potency from batch to batch.

Because iodine content rather than biological assay is used to measure the standard of many desiccated thyroid products, biologic activity can vary from batch to batch. Even when biologic assay is employed, biologic activity can only be approximated.

1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

Every batch of Synthroid® T_4 is of controlled potency. (sodium levothyroxine, U.S.P.) FLINT

SYNTHROID is T_4. It provides your patients with everything they need for complete thyroid replacement therapy.

1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

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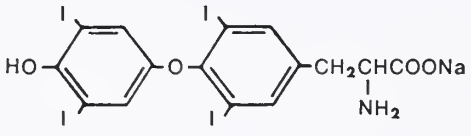
Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets,** taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets,** the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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*U.S. Pat. 2,889,363

Case Reports

An Unusual Case of a Bullet Embolus by Dennis F. Pupello, M.D., Martin Lipton, M.D. and Norman E. Shumway, M.D.

On April 9, 1970, following an altercation, a 23-year-old man was admitted to the emergency room complaining of back and right leg pain. The blood pressure on admission was 90/60. The pulse rate was 110 per minute and regular. Breath sounds were decreased on the right and a small puncture wound was noted just below the tip of the right scapula. No other wounds were noted, although the right leg was cool and no pulses were palpable below the femoral. A portable chest film disclosed several metal fragments adjacent to a fractured right eighth rib, as well as a small pneumohemothorax. There was no evidence of cardiac tamponade. A chest tube was inserted and 400 cc of blood evacuated. A second portable x-ray of the abdomen and pelvis disclosed a missile lodged near or in the right common femoral artery. The patient's condition stabilized after restoration of plasma volume and he was transferred to Stanford University Hospital for an emergency aortogram. A contrast study disclosed no evidence of trauma to the thoracic aorta; however, the missile was found to lie within the common femoral artery.

From a review of the literature on penetrating injuries of the heart one can conclude that there is no unanimity of opinion with respect to management. There are two main schools of thought. One, initial pericardiocentesis and close observation or two, immediate surgery for all patients with penetrating heart wounds. In general, we favor a policy of immediate thoracotomy or sternotomy when continued hemorrhage rather than tamponade is a major problem.

In the patient presented here, obviously perforation of the heart or pulmonary vein had occurred, allowing the missile to enter the left ventricle with embolization to the right femoral artery; however, there was no clinical evidence of cardiac tamponade, thereby obviating the necessity of pericardiocentesis. The right hemothorax was evacuated with a tube thoracostomy and perfusion pressure remained adequate after restoration of plasma volume. Under local anesthesia the bullet was removed without difficulty. The patient's condition remained stable postoperatively and he was discharged on the eighth postoperative day on no medications.

Dr. Pupello, Tampa General Hospital, Davis Islands, Tampa 33606.

Dysplastic Kidney With Duplicated Bladder and Ureters by M. H. Antar, M.D.

A 22-year-old woman was admitted to the gynecology service for termination of pregnancy. At amniocentesis 850 cc of brown-colored fluid was removed and 200 cc of 20% normal saline injected. The following morning she was afebrile, had no labor pains, and voided without difficulty. In the afternoon nausea developed and x-ray showed a possible mass in the right pelvis which proved by amniogram to be a multilocculated cyst filling most of the lower abdomen. That night her temperature rose to 101 F and the abdomen was found to be generally tender.

The morning of the second day she was afebrile. That night cramps began in the abdomen and examination revealed it to be tender and distended with a large mass filling the pelvis and deviation of the cervix extremely to the right. This was believed to be a distended bladder and catheterization produced about 500-700 cc of residual urine. The temperature went up to 100.4

Dr. Pupello is Director, Cardiac Surgical Unit, Tampa General Hospital, Tampa.

From the Department of Urology, University Hospital, Jacksonville.

F and the abdominal pain continued. The hemoglobin was 8.0 gm.

On the third day she was taken to surgery. Exploration revealed a four-month pregnancy, dilated left kidney with double collecting system ending in a sac which appeared to be congenital, left hypoplastic kidney and two megaureters ending in a blind sac, later identified as a bladder.

The right kidney and ureter were also dilated and constriction at the pelvic brim was thought due to displacement of the uterus to the right. Only one right ureteral orifice of the bladder was identified and there was no trigone. A catheter was placed in the right kidney and brought out through the bladder and suprapubic area. A left nephroureterectomy was performed, the blind sac removed, also a hysterectomy, and suprapubic cystostomy.

Postoperatively the patient did very well. About a week later an intravenous pyelogram showed a hydronephrotic right kidney with ureter dilated to the pelvic brim. An upper GI series revealed no abnormalities except questionable fundal irregularity which was not considered significant. Barium enema showed no congenital abnormalities. A renal scan showed uniform uptake by the single large right kidney.

The kidney measuring 7 x 3 x 2 cm had dysplastic features, markedly dilated pelvis and calyceal system, and a few areas of grossly recognizable renal parenchyma. Heterologus elements were not present but primitive tubules were evident, surrounded by a fibrous tissue cuff.

Two extremely dilated ureters arose from the pelvis. Both were approximately 25 cm long, up to 5 cm in diameter, had extensive fibrosis and focal calcification of the walls. Located at the distal-most aspect of the medial ureter was a saccular dilatation 8 cm in diameter. The pelvis and ureters were without urothelium in many areas; where present it was attenuated. There was some muscular hypertrophy, though in many places the degree of fibrosis and chronic inflammation of the wall was the most striking feature.

Both ureters narrowed to 1 cm in diameter with orifices 4 cm apart before entering the left lateral aspect of a saccular structure. On the right side was a third tubular structure 3 cm in length which also entered the sac. Centrally it contained a lumen up to 0.5 cm in diameter; however, a probe could not be passed from this into the sac and both proximally and distally it appeared to end blindly. Most of the saccular structure's wall consisted of fibrous tissue. Smooth muscle up to 1.5 cm in thickness was grossly recognizable at the ureteral orifices.

The tubular structure located at the right of the sac was lined with urothelium and had histologic features quite compatible with those of a ureter. The distal saccular structure into which the ureters entered was without urothelium in the areas examined. Much of the wall was fibrous tissue with little smooth muscle. Where apparent, smooth muscle appeared as interlacing bundles.

Acknowledgement: Dr. Rosaline Saffos from the pathology department, University Hospital, for writing and reviewing the pathology section and also the secretaries at the James L. Borland Medical Library for their help in searching the literature.

▶ Dr. Antar, 800 Lomax Street, Jacksonville 32204.

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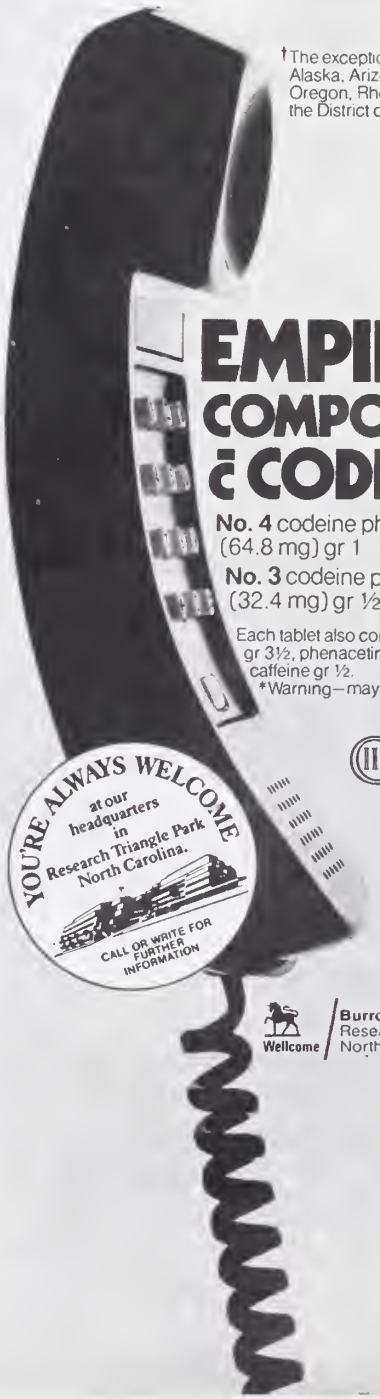

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MEREDITH MALLORY, M.D.
(1889-1975)

In Memoriam

Florida has lost another of its "grand old men of medicine." On Sept. 11, 1975, Meredith Mallory, M. D. passed away quietly in his sleep.

Dr. Mallory was born in Wichita, Kansas, April 21, 1889, the son of Albert Douglas and Susan B. Mallory, and spent most of his boyhood in Batavia, Illinois. He was awarded a B. A. from the University of Illinois in 1911, where he was a member of the Chi Psi Fraternity. He earned his M. D. degree from Harvard School of Medicine in 1915. Graduation from medical school was followed by an internship at the Iowa Methodist Hospital, and later by postgraduate work at Harvard Medical School and Cook County Hospital.

In 1916 he entered the practice of medicine with the late Walter L. Biering in Des Moines, Iowa. Practice was interrupted in October 1917 when he was commissioned as a First Lieutenant in the Army Medical Reserves. In 1918 he successfully stood the examination for the Regular Army Medical Corps. In 1919 he resigned from the Army and returned to Des Moines to reenter practice with Dr. Biering.

In 1922, because of Mrs. Mallory's health he was advised to take her to Florida. That year he entered practice in Orlando, initially in the office with Dr. John McEwan and Dr. Gaston Edwards. Later he entered solo practice and became the first recognized specialist in Internal

Medicine in the Orlando area.

From the time he started practice until his retirement at approximately seventy five years of age he was active in civic and medical affairs. He often stated that every physician's first duty was to be a good citizen. His record in civic affairs in Orlando bears this out. During his active years he was a director of the local Red Cross and of the Orlando Chamber of Commerce. He was active in the Orlando High School Athletic Association for twenty years; president of the Orlando Civic Music Association during World War II; a member of the American Legion Forty and Eight organization, and a member of the Orlando Rotary Club. He was a founding member and the first vice president of the University Club of Orlando, and its president in 1930. He was also a member of the University Club of Chicago. In 1946 Rollins College awarded him an honorary degree because of his participation in civic affairs, and in May 1958 the Orlando Sentinel Star honored him as "The Man of the Week."

Involvement in civic affairs in no way interfered with his interest in his patients and his concern about the standards and ethics of medicine. He was active throughout the years at county, state and national levels. He was a member of the Florida Medical Association, the American Medical Association and the Southern Medical Association. For years he was chief of the Medical Service at the Orange Memorial Hospital, was a past president of the staff, and was the first physician to serve as a member of the Board of Governors of the hospital.

He was a past president of the Orange County Medical Society (1931) and was active in committee work at the county level. He served as a delegate to the state Association, and was Florida's only delegate to the AMA from 1934 to 1944. He again served as one of the state's delegates from 1959 to 1965. He served one year as vice president of the Florida Medical Association, and served a stint on the Blue Shield Board of Governors, and was member of the Board of Governors of the Florida Medical Association from 1953 to 1961. He was one of the founding members, and in 1952 was state chairman of the Florida Medical Committee for Better Government. From 1947 to 1966 he served as State Medical Consultant to the Florida Rehabilitation Agency. He was a Fellow of the American College of Physicians since 1931 and a Diplomate of the American Board of Internal Medicine since 1937. In 1964 he was awarded the Certificate of Merit by the Florida Medical Association.

Dr. Mallory was married to Mary S. Jones for over fifty years, who predeceased him. He is survived by three children Meredith Mallory Junior, Norman Douglas Mallory and Mary Jane Mallory. Funeral services were conducted from the church of his faith, The Episcopal Cathedral of Saint Luke in Orlando, Florida on September 13, 1975. — W. Dean Steward, M.D., Jacksonville.

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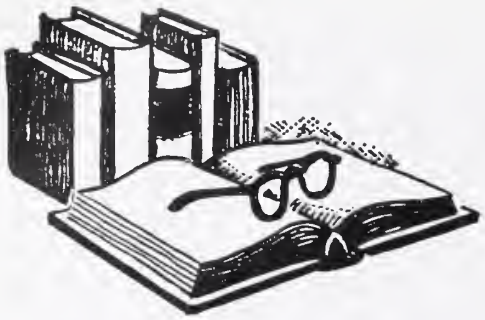

Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Editor's Note: Beginning with the October issue, F. Norman Vickers, M.D., of Pensacola, has been designated as Book Review Editor. With this appointment, The Journal hopes to bring to its readers an expanded coverage of selected topics of medical literature.

Additionally, in the firm belief that physicians should be well-read, certain books will be reviewed which are not solely medical, but which the Book Review Editor feels to be of special merit and interest to our readers.

Your suggestions and comments regarding this innovation will be welcomed. — The Editor.

Review of Medical Physiology, 7th Edition, by William F. Ganong, M.D. 587 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

This softbound book, written by the Professor of Physiology at the University of California School of Medicine, is an outgrowth of the teaching system at that University. It is a concise summary of mammalian and human physiology which medical students and others can utilize profitably.

Almost every chapter relates to medical problems, and is explained on a physiologic basis, sometimes humorously. For example: In describing an adequate stimulus for a particular reflex, there is the dramatic example of the dog's scratch reflex. "The response to multiple linear touch stimuli results in vigorous scratching of the area stimulated. If the multiple touch stimuli are widely separated or are not in a line, the adequate stimulus is not produced and no scratching is produced. Fleas crawl, but they also jump and this separates the touch stimuli so that an adequate stimulus is not produced. It is doubtful if the flea population would long survive if they did not have the ability to jump."

There are 40 chapters which cover eight main body systems, and which are satisfactorily cross-indexed for ready reference. Each section is comprehensive and instructive and detailed sufficiently to prevent casual reading. The list of references appearing at the end of each chapter is adequate to permit further reading for expansion of essential principles of physiology. Hundreds of drawings, tables, biochemical reactions and formulae are found at every step.

Normal and abnormal physiology of the various body systems are discussed and correlated, including Endocrinology and Metabolism. The Appendix includes a list of the best textbook references on Physiology, including sources of summaries of current research. Normal values and the Statistical Evaluation of Data, abbreviations, symbols commonly used in physiology, and Standard Respiratory Symbols are also found in the Appendix.

In the chapter on Neurophysiologic Basis of Instinctual Behaviour and Emotions, there is clinical correlation in sexual behaviour. For Example: "the administration of testosterone to homosexuals intensifies their homosexual drive but does not convert it to a heterosexual drive."

On the whole, this review is a worthy addition to the medical library of student and practitioner alike. It provides a physiologic basis for medical practice.

Philip Leavitt, M.D.
Hollywood

Eating Disorders by Hilde Bruch, M.D. 396 Pages, Price $12.50. New York, Basic Books, Inc., 1973.

Dr. Bruch is Professor of Psychiatry at Baylor. She states that her study of eating disorders has extended over a period of 40 years. She has focussed her attention on those extreme cases of refractory obesity and anorexia nervosa. From the average practicing physician's point of view, this book will have little appeal; however, it is fascinating to review Dr. Bruch's insights over this period of time.

"At this moment a high protein diet which the New York City Health Department has prescribed for years in its obesity clinic supports a multimillion dollar business by being propagated in fashionable detail by Weight Watchers."

In commenting on fad diets, Dr. Bruch says ". . . . many fat people, in particular those with personality problems, prefer rather unusual diets that bring visible results more quickly. . . . It is my impression that it is the very strangeness that makes these diets effective."

She does not waste time on diets but tries to deal with what she considers to be the underlying problem. "The therapeutic goal is to make it possible for a patient to uncover *his own* abilities, *his* resources, and inner capabilities for thinking, judging, and feeling.

F.N.V.

The Dilemmas of Euthanasia edited by John A. Behnke and Sissela Bok. 200 pages. Price $2.95. New York, Doubleday & Company, Inc., 1975.

Small paperback with seven chapters by various authors on aspects of euthanasia and dying. Good references. Appendices include a Living Will and Patient's Bill of Rights adopted by the American Hospital Association. This will have limited appeal to the lay public and the profession.

F.N.V.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975

Problem-Directed and Medical Information Systems edited by Marshall F. Driggs, M.D. 241 Pages. Illustrated. Price $15.45. New York, Intercontinental Medical Book Corporation, 1973.

Review of Physiological Chemistry, 15th Edition by Harold A. Harper, Ph.D. 570 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

The Homosexual Matrix by C. A. Tripp, 314 Pages. Price $10.00. New York, McGraw-Hill Book Company, 1975.

Information for Authors

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References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

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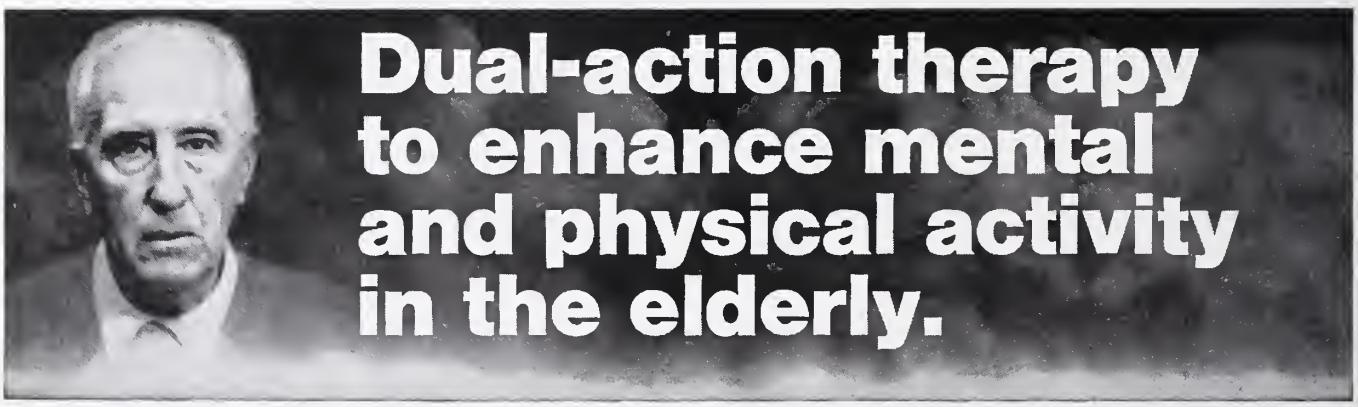

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Deaths

Atkinson, Karl Sinclair, Miami; born 1935; Howard University School of Medicine, 1969; member AMA; died May 10, 1975.

Beekman, Franklin, Lighthouse Point; born 1929; Boston University, 1956; member AMA; died May 5, 1975.

Brannen, Ollie Colquitt, Sun City; born 1895; Emory University, 1922; member AMA; died July 22, 1975.

Brusca, Donald D., Clearwater; born 1908; Medical College of Virginia, 1936; member AMA; died August 2, 1975.

Carlisle, James L., West Palm Beach; born 1888; Tulane University, 1922; member AMA; died April 18, 1975.

Covalt, Nila Kirkpatrick, New Smyrna Beach; born 1905; Indiana University, 1933; member AMA; died June 21, 1975.

Cura, Angela, Miami born 1918; University of Havana, 1952; member AMA; died July 26, 1975.

del Real, Ricardo Eustaquid, Fort Lauderdale; born 1935; Tulane University, 1960; member AMA; died April 23, 1975.

Derrick, Walter Ansell Jr., Fort Walton Beach; born 1940; Tulane University, 1966; member AMA; died September 25, 1975.

Gerspacher, Thomas Stone, Miami; born 1906; University of Louisville, 1933; member AMA; died May 12, 1975.

Goyings, Ezra Jr., Winter Park; born 1924; Hahnemann Medical College, 1946; member AMA; died July 10, 1975.

Groom, Joseph John, Coral Gables; born 1914; Ohio State Medical School, 1941; member AMA; died August 16, 1975.

Hicks, David Yancey Jr., Orlando; born 1913; Georgia Medical College, 1937; member AMA; died May 3, 1975.

Kuebler, Charles William, Mary Esther; born 1944; University of Mississippi, 1969; member AMA; died February 9, 1975.

Lawson, George Walter, Miami; born 1909; Georgetown University, 1936; member AMA; died June 16, 1975.

Lee, Robert Moseley, Miami; born 1920; Emory University, 1943; member AMA; died August 11, 1975.

Long, Gerald A., Tallahassee; born 1910; St. Louis University, 1936; member AMA; died May 15, 1975.

Mallory, Meredith, Orlando; born 1889; Harvard Medical School, 1915; member AMA; died September 11, 1975.

Marr, Norval Mason, St. Petersburg; born 1896; University of Cincinnati, 1924; member AMA; died August 1, 1975.

Marx, Isidore, Miami; born 1907; Long Island Medical College, 1931; member AMA; died—date unknown.

Merrick, Charles Gordon, Fort Myers; born 1886; Queens University, 1913; member AMA; died July 23, 1975.

Migliore, Anthony Diblasi Sr., Orlando; born 1901; Tulane University, 1928; member AMA; died May 7, 1975.

Mosco, James Arthur, Tallahassee; born 1912; St. Louis University School of Medicine, 1937; member AMA; died June 17, 1975.

Munoz, Hernando, Tallahassee; born 1920; National University, 1950; member AMA; died May 23, 1975.

Norley, Theodore, West Palm Beach; born 1917; Hahnemann Medical College, 1943; member AMA; died August 11, 1975.

Norton, William James, Punta Gorda; born 1926; University of Arkansas, 1953; member AMA; died May 30, 1975.

Padorr, Marie McVey, Miami; born 1901; Northwestern Medical School, 1932; member AMA; died September 8, 1975.

Pierard, Albert Alexander, Brandon; born 1922; University of Kansas, 1954; member AMA; died April 20, 1975.

Raynolds, Arthur Hidden, St. Petersburg; born 1900; P & S Columbia University, 1926; member AMA; died July 11, 1975.

Rogers, Mary Josie, Daytona Beach; born 1876; Hahnemann Medical College, 1907; member AMA; died—date unknown.

Rowland, John Henry Jr., Jacksonville; born 1929; New York University, 1956; member AMA; died May 30, 1975.

Rowlett, William Monroe. Tampa; born 1884; Emory University, 1909; member AMA; died July 29, 1975.

Sayers, James Rolland, Palatka; born 1898; Oklahoma Medical College, 1929; member AMA; died May 8, 1975.

Shannon, William Arthur, Sarasota; born 1898; George Washington University, 1924; member AMA; died August 31, 1975.

Smith, Burdette, Tampa; born 1882; Atlanta School of Medicine, 1910; member AMA; died July 3, 1975.

Weinstein, Philip, Miami; born 1896; Washington University, 1956; member AMA; died August 17, 1975.

Wilkison, Earl Edward, Tallahassee; born 1917; Virginia Medical College, 1945; member AMA; died June 1, 1975.

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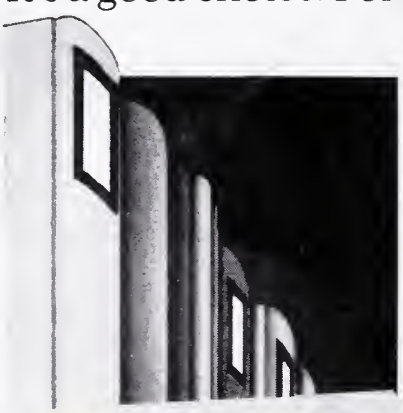

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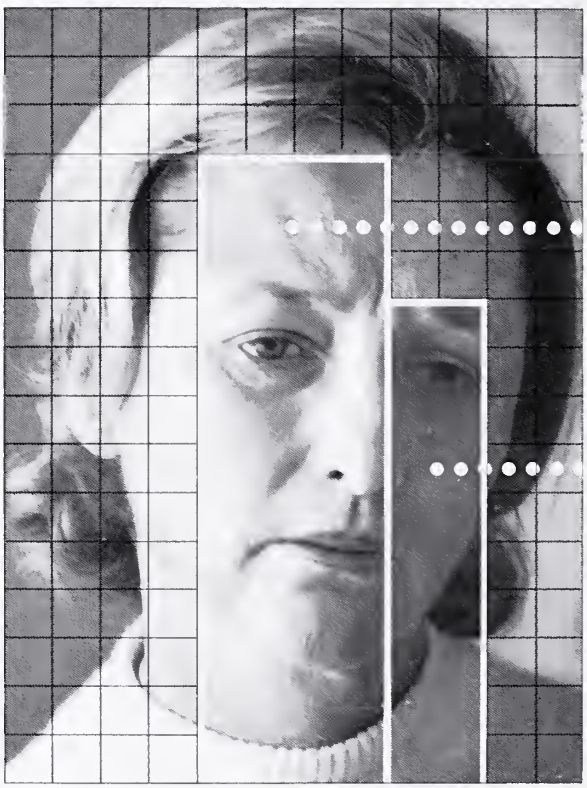

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DECEMBER COVER — The December cover is a holiday greeting symbolizing PEACE — eagerly sought by all generations but rarely achieved over a continuum of time. It is a pen and ink sketch by A.L.S., a close friend of the Editor.

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is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains Aerosporin* brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units, neomycin sulfate 5 mg (equivalent to 3 5 mg neomycin base), special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx) foil packets

INDICATIONS. Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS**: Not for use in the eyes or external ear canal if the eardrum is perforated This product is contraindicated in those individuals who have shown hypersensitivity to any of the components **WARNING**: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS**: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS**: Neomycin is a not uncommon cutaneous sensitizer Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

President's Page

The Man In The Glass

I would like to share with you a short verse which I have kept on my wall and reviewed from time to time as the occasion demanded. It is entitled, "The Man In The Glass."

When you get what you want in your struggle for self,
And the world makes you king for a day
Just go to a mirror and look at yourself
And see what that man has to say.

For it isn't your father, mother or wife
Who judgement upon you must pass;
The fellow whose verdict counts most in your life
Is the one staring back from the glass.

Some people may think you a straight shootin' chum
And call you a wonderful guy,
But the man in the glass says you're only a bum
If you can't look him straight in the eye.

He's the fellow to please — never mind all the rest,
For he's with you clear up to the end.
And you've passed your most dangerous, difficult test
The man in the glass is your friend.

You may fool the whole world down the pathway of life
And get pats on your back as you pass,
But your final reward will be heartaches and tears,
If you've cheated the man in the glass.

Perhaps it would be advisable for us to review in a timely, unbiased manner how we are doing in our job. In other words, as you look in the glass, would you want yourself for a doctor. It is easy to recall our good diagnoses, our night responses, our charity cases, our grateful patients, and answer this question in the affirmative. But which of us cannot honestly recall other instances when the reply might have been negative? Perhaps an evening when we failed to respond, a busy afternoon schedule when we refused an old patient's visit, an anxious waiting relative forgotten following a surgical operation, a review of our charges in respect to the patient's ability to pay and/or the service rendered, or possibly a self analytical look at the timely use of consultants or our own attention to ongoing postgraduate education.

These matters are even more imperative today than in years past if we are to maintain our exalted position in public opinion polls. More imperative since the media seem intent on degrading the medical profession or at least giving more copy to our occasional shortcomings than to the overall standards of excellence maintained by our profession. Programs such as "Medical Story" have replaced "Dr. Kildare," and "M A S H" supposedly represents the cross-section of professional competence and morality in an overseas mobile Army surgical hospital.

It is my firm conviction that we should answer these critics promptly and factually. That we should achieve exposure through the media and tell our story. This we can do with credibility and believability only if our record of service remains unblemished.

The Florida Medical Association is embarking upon a major public relations campaign in addition to a major legislative thrust this year. Neither of these programs can succeed if we physicians act like merchants and particularly if we keep merchants hours.

Let us look in the glass and review our own image and our devotion to the profession, and more importantly, to our patients. Let those of us in academia review our selection of medical students and our methods of promoting and graduating them. Let us ask ourselves if we would want this applicant or student to be our doctor? Let us ask if our residents in training are truly selected and promoted on the basis of merit and if we would want he or she to be our personal treating specialist. Let each of us ask ourselves as we look in the glass, would I want me for a doctor?

There's something special about children vomitin

The risk of dehydration . . . plus the psychological stress on both mother and child . . . greatly increases the urgency in controlling vomiting in children. In addition, there is, of course, need to avoid the extrapyramidal problems associated with phenothiazine medications.

That's why special medication is preferred

WANS® CHILDREN SUPPRETTES™ are specially formulated to stop vomiting and nausea in children—rapidly and with minimal complications.

- WANS are administered rectally—often the best route in the vomiting patient.
- The exclusive WANS formula provides both pyrilamine maleate and sodium pentobarbital for effectiveness . . . contains no phenothiazines or local anesthetics.
- The unique Supprette delivery system rapidly releases effective levels of medication . . . with no oils or fatty acids to affect absorption or cause local irritation.
- WANS SUPPRETTES require no refrigeration . . . no lubrication other than water . . . and dissolve completely, with virtually no leakage.

And for children over 12 years of age and adults suffering from nausea and vomiting, consider higher-strength WANS® No. 1 or WANS® No. 2.

A special favorite* of Florida physicians in controlling childhood vomiting

WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg, sodium pentobarbital 30 mg

Warning: may be habit forming

*Based on usage [illegible] data gathered by independent research organization

DESCRIPTION: WANS® Children: (Blue) pyrilamine maleate 25 mg and pentobarbital sodium* ½ gr (30 mg) scored for ½ dosage. WANS® No. 1: (Pink) pyrilamine maleate 50 mg and pentobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. WANS® No. 2: (Yellow) pyrilamine maleate 50 mg and pentobarbital sodium* 1½ gr (100 mg) scored for ½ dosage.

*WARNING: may be habit forming.

CONTRAINDICATIONS: Infants under 6 months. Acute intermittent porphyria, known hypersensitivity to barbiturates or antihistamines, known previous barbiturate addiction, severe hepatic impairment, CNS injury, senility, and presence of uncontrolled pain.

WARNINGS: Barbiturates may be habit forming. Pre-existing psychologic disturbances may be aggravated. Idiosyncratic reactions may occur. Acquired sensitivity may result in allergic reactions. Safety in pregnancy has not been established.

PRECAUTIONS: Use cautiously with other sedative, hypnotic or narcotic agents. Use with caution in patients with acute or chronic hepatic disease, fever, hyperthyroidism, diabetes mellitus, severe anemia, congestive heart failure, or a history of drug dependence or suicidal tendencies. May impair alertness and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

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Alcon Laboratories, Inc.
Fort Worth, Texas 76101

When sequential contraception is preferred...

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Ortho-Novum SQ provides good cycle control

provides a low sequential dosage

effective in clinical trials, with a pregnancy rate of 0.43 per 100 woman years

generally well tolerated†

available in the unique DIALPAK* Tablet Dispenser

Ortho-Novum SQ

TRADEMARK

Each white tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

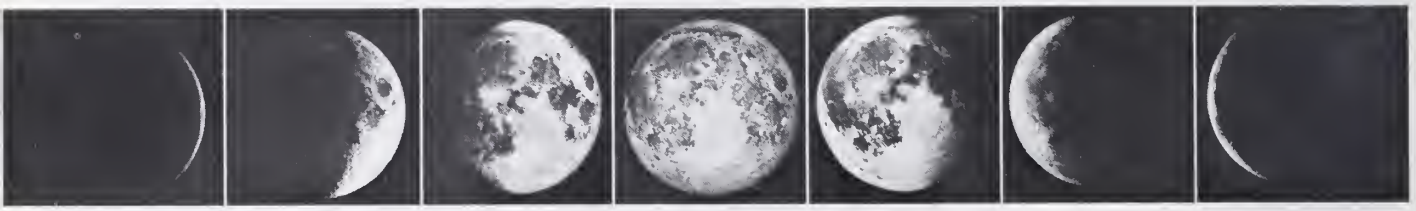
†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

*TRADEMARK

See prescribing information on following page.

OJ 622-5

In sequence...



Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SQ Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0.08 mg, and blue tablets containing both mestranol 0.08 mg and norethindrone 2.0 mg.

Action: Gonadotrophin suppression

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy. Liver disease has also been reported, and the physician should be alert to its earliest manifestations.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication: Contraception

Contraindications: 1. Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions. 2. Markedly impaired liver function. 3. Known or suspected carcinoma of the breast. 4. Known or suspected estrogen-dependent neoplasia. 5. Undiagnosed abnormal genital bleeding. 6. Known or suspected pregnancy.

Warnings: 1. The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis. Should any of these occur or be suspected, the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives. There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country.[4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4.4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users.

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group. This study in its interim analysis states, "A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk." The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users. The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations.

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment.

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4.1 to 9.5 times greater in users than in non-users. A comparable estimate for hemorrhagic stroke was 2.0.

None of the American studies was designed to evaluate a difference between products. However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products.

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users. It has been recommended that therapy be discontinued at least one month prior to elective surgery.

2. Discontinue oral contraceptive medication if there is gradual or sudden partial or complete loss of vision; proptosis or diplopia; onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe; papilledema; or any evidence of retinal vascular lesions.

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy.[11,12] The safety of ORTHO-NOVUM SQ in pregnancy has not been demonstrated. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

5. Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed before prescribing oral contraceptives and periodically during their administration and should include special reference to breasts and pelvic organs, including Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. 2. Endocrine and possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ. Therefore, if such tests are abnormal in a patient taking ORTHO-NOVUM SQ, it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated. 6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 7. Any possible influence of prolonged ORTHO-NOVUM SQ therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORTHO-NOVUM SQ therapy. 9. The age of the patient constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ may mask the onset of the climacteric. 10. The pathologist should be advised of ORTHO-NOVUM SQ therapy when relevant specimens are submitted. 11. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids. 12. Cholestatic jaundice has been reported in users of oral contraceptives. If this occurs, ORTHO-NOVUM SQ should be discontinued. This condition is more likely to occur in patients who have experienced cholestatic jaundice of pregnancy. Patients with a history of cholestatic jaundice of pregnancy should be carefully observed during ORTHO-NOVUM SQ therapy.

Adverse reactions observed in patients receiving oral contraceptives: A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism, cerebral thrombosis and hemorrhage, gallbladder disease.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis; hepatic lesions with or without intra-abdominal bleeding.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, rash (allergic), mental depression; change in weight (increase or decrease), breast changes (tenderness, enlargement and secretion), changes in cervical erosion and cervical secretions; suppression of lactation when given immediately post-partum; rise in blood pressure in susceptible individuals.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post-treatment, which tends to occur more frequently in women with a history of menstrual disorders; premenstrual-like syndrome; changes in libido; changes in appetite; cystitis-like syndrome; headache; intolerance to contact lenses; nervousness; dizziness; fatigue; backache; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruptions; itching; vaginitis.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function—increased sulfobromophthalein retention and other tests; coagulation tests—increase in prothrombin, Factors VII, VIII, IX and X; decrease in anti-thrombin III; increase in platelet aggregability; thyroid function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

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Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

DEPARTMENT OF MEDICINE

ELEVENTH ANNUAL

POSTGRADUATE COURSE

"INTERNAL MEDICINE 1976"

January 25-30, 1976

Fontainebleau Hotel **Miami Beach, Florida**

Co-Directors:
William J. Harrington, M.D., Eric Reiss, M.D.

Program Coordinator:
Jose S. Bocles, M.D.

THE OBJECT OF THIS COURSE, THE ELEVENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS. EACH SUBSPECIALTY WILL BE INTRODUCED BY A STATE OF THE ART LECTURE GIVEN BY A DISTINGUISHED AUTHORITY.

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Neal S. Bricker, M.D., Professor and Chairman, Department of Medicine, Albert Einstein College of Medicine, Bronx, New York, Renal Diseases.

William J. Daughaday, M.D., Professor of Medicine, Washington University School of Medicine, St. Louis, Missouri, Endocrinology and Metabolic Diseases.

J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia, Cardiovascular Diseases.

Donald J. Massaro, M.D., Professor of Medicine, The George Washington University School of Medicine, Washington, D.C., Pulmonary Diseases.

Louis Weinstein, Ph.D., M.D., Visiting Professor of Medicine, Harvard Medical School, Physician, Peter Bent Brigham Hospital, Boston, Massachusetts, Infectious Diseases.

Maxwell M. Wintrobe, M.D., Ph.D., Distinguished Professor of Medicine, University of Utah College of Medicine, Salt Lake City, Utah, Hematologic Diseases.

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They will be held daily and consist of simultaneous small groups in which illustrated aspects of each subspecialty will be presented, followed by open discussions and topics not formally reviewed in the lectures.

This course is fully accredited by the Council on Medical Education of the American Medical Association and is acceptable for credit toward the Physician's Recognition Award.

Application to the American Academy of Family Practice has been made for credit.

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$250—Physicians $150—Physicians in training

Checks should be made payable to:

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No refunds after December 25, 1975. An administrative fee of $20.00 will be charged for any refunds made.

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University of Miami School of Medicine
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Limited Registration — Register Early!

HOTEL:

The Fontainebleau Hotel in Miami Beach, has reserved a limited number of rooms at the special rate of $40 single and $44 double per day. These rates are available only from January 22 to February 2, 1976, subject to availability. The hotel has several golf courses with complimentary greens fees provided, two outdoor swimming pools, private beach, an ice skating rink, complete gymnasia, bowling lanes, tennis courts, shuffleboard and a billiard room.

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and als meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY
For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.
The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.
Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.
Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.
A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.
Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:
A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.
To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).
Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.
Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.
If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.
Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.
The pathologist should be advised of estrogen therapy when relevant specimens are submitted.
Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.
Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.
The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.
Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.
Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.
If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.
Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.
Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.
Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)
No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.
No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.
No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

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New York, N.Y. 10017

LEGISLATIVE NEWS

In order to fully update all members of the Florida Medical Association effectively we would like this column to be introduced into the material which we hope will be published regularly in The Journal.—James B. Perry, M.D.

The Council on Legislation and Regulations has submitted a number of proposals to the Board of Governors concerning position on various Bills in the legislature. In the last session some 300 Bills, having some direct or indirect application to medicine or the practice thereof, were introduced from the House and Senate. It is of more than casual interest that a number of them had at least some meritorious reason for being introduced. It is also of even greater significanec that because of "special considerations" or obvious detriment to the practice of medicine, the posture of the FMA on these otherwise worthy measures was one of negativism.

It is the hope of all concerned that through the long hours of multiple conferences and meetings through the summer months that a positive approach to many of the problems deserving consideration can be obtained.

The Council is particularly concerned about the problems of cost containment and availability of health care in rural and ghetto areas. It is anticipated that several suggested solutions will be developed for the Florida Legislature to consider, and that these ideas will be a basic part of the Association's 1976 legislative program.

It is the Council's desire also to have massive input from specialty groups. Many of the specialty societies have, through their own sometimes massive consideration and accumulation of information, added constructive thought that hopefully will culminate in a positive program. Several thoughts and recommendations on the PLI (Professional Liability Insurance) issue have been accomplished and it is to this issue that much constructive activity is accomplished.

Special assessments to raise necessary dollars will be forthcoming if all members agree. We will have a united concerted distilled plan for advancement against our problems but this will not be finalized until sometime after the Florida Medical Association meeting in January 1976.

We would urge that if any specialty society feels like donating dollars, they contact the Tallahassee office to see that the money is wisely spent. All too often in the past some goals that tend to engender dollar donations and action, though in themselves good and admirable, often cause the overall paramount objective to be shortsighted or overlooked. The result is that too much valuable political credit is used on results that in the long run does not help Florida medicine or the involved specialty group. This, unfortunately, is too narrow a goal. Hired lobbyists often are excellent in their appointed tasks, but do not have the entire global concept of total commitment thoroughly entrenched in their cranial vaults. The battle is nevertheless won, but the war could be lost because of shortsightedness. We need the specialty groups and their executive committees to work closely with the legislative committees and the Council on Specialty Medicine, not just in the county and state, but nationwide. We need the concerted efforts and function of all the committees and perhaps even Ad Hoc committees with dialogue between all of them. Perhaps one of the more excellent examples of this in action is the work and fine cooperation of the Florida Psychiatric Society with the Council on Specialty Medicine, the Council on Medical Systems and the Council on Legislation and Regulations. We should offer applause and appreciation for their help.

In 1974, the Council on Specialty Medicine developed guidelines to assure coordination of legislative activities by the specialty groups with the FMA. The key parts of this document, which was approved by the FMA Board of Governors are:

a. Those specialty groups with particular interests and concerns should have the privilege of

developing legislative programs of their own, provided that these programs are not in conflict with FMA policy and provided that these programs are coordinated with the Chairman of the Council on Legislation and Regulations.

b. The route by which a FMA recognized specialty group should present its desire to pass or defeat legislation should be through the Council on Specialty Medicine on which it is duly represented. The Council should review the legislation and recommend to the FMA Board of Governors a level of support or opposition.

c. Professional lobbyists contracting with specialty groups for legislative activities should work out priorities with the manager of the FMA Capital office and reasonably subrogate and coordinate their activities to those issues pertinent to general medicine.

d. The Council on Legislation and Regulations will provide general supervision necessary to insure coordination of Tallahassee activities of specialty group staff.

These guidelines and the others in this policy should allow for all physicians and specialty groups to pursue in a coordinated manner those legislative objectives of concern to all.

At our meeting on November 6th, we hope to finalize some specific recommendations to be sent before reference committees at the time of the special Florida Medical Association session in January. Additional input from any and all sources will be accepted until final resolutions and drafts are completed after the 1st of February 1976.

If you have the answer to PLI, cost containment, national compulsory health insurance or any of our multitude of problems or facets thereof, please communicate before you no longer are free to do so. We need your thoughts and constructive ideas two months ago.

James B. Perry, M.D., Chairman
FMA Council on
Legislation and Regulations
Fort Lauderdale

"I have nothing to offer but . . ."

That line from Winston Churchhill's famous speech when he became Prime Minister in 1940 summarizes my feelings on assuming the position of Chairman of the Committee on State Legislation. Dr. Astler asked me to do this job as Dr. George Evans of Tallahassee, the former chairman, is moving to Dublin, Georgia. George will be sorely missed by Florida medicine as he was very enthusiastic and effective. I pledge to all members of FMA to do my utmost to fill his shoes.

This article is the first of a series that will appear in each issue of JFMA on legislative matters. The purpose of it is to inform, educate and establish a dialogue in this area so crucial to Florida medicine. The committee needs and welcomes input from every member of our Association, and we are as near as your telephone or the post office. The members of this committee are: J. Carlisle Hewitt, M.D. and Victor J. Martinez, M.D., Tampa; Julian H. Groff, M.D., North Miami Beach; Donald O. Alford, M.D., Thomas P. Wood, M.D., Jack W. MacDonald, M.D., Tallahassee.

Please communicate with us at any time. We promise to listen and consider any serious suggestions put forth by any member. Be careful, however, if you have a good idea you may be appointed chairman of a subcommittee to carry out your idea.

The legislative committee has held meetings this year in Miami, Orlando, Tallahassee and Jacksonville. Officers and county medical society executives have been invited to these meetings, along with representatives of the specialty groups. Much valuable input has been gained from these meetings, and it is planned to continue to rotate the site of the committee meetings. Times, dates and places of future meetings will be announced through this page, and any member of the FMA is welcome to attend these committee meetings.

Three areas at least are going to engage the attention of Florida medicine in the next legislative session. These are 1.) Health Care Cost Containment 2.) Availability of Health Care to rural areas and retirement communities, and 3.) Professional Liability Insurance. There will be a special called session of the House of Delegates in January to consider and decide FMA policy in these areas, among other issues. If you have ideas, now is the time to bring them before the delegates of your county medical society.

The Committee on State Legislation is currently taking in information from all sources so that we can recommend to the House of Delegates legislative goals and a priority list. Much consideration will enter into this, and we have already made some recommendations to the Board of Governors. The Tallahassee office will be strenthened with new people, and more office space will be available about January 1st. You can communicate your views directly to Donald "Scotty" Fraser if you wish. He is our Director of Public Affairs, and the address is 346 Barnett Bank Building, Tallahassee 32301, telephone (904) 224-6496.

A number of groups of Florida physicians have expressed interest in hiring their own lobbyist in Tallahassee. This is of course your privilege in a democratic society. Before you do that, however, be sure you do not run afoul of the IRS if your organization is a nonprofit one. In addition, if your group does make such a decision, I urge you to contact either Scotty Fraser or me for some suggestions on who would be an appropriate person to hire. Hiring the wrong person could undo your own efforts and run at cross purposes to the FMA endeavors. If we can have specialty group lobbyists working in concert with FMA, the effectiveness of both groups will be enhanced. This is no time to present a divided house to the legislature. Our opponents will take full advantage of such a situation and render us impotent to accomplish anything.

The thrust of the Committee on State Legislation will be to try to present constructive proposals in response to health care issues. Where legislation is proposed that is detrimental in some way to the public and ourselves, we will try to develop positive alternative proposals so that a compromise may be reached that will accomplish good for all. Only as a last resort do we want to be placed in a position of mere opposition. Organized medicine has too often simply been "agin" proposals. Such a position earns you very little unless the proposal is obviously bad, a nuisance on its face. Such legislation often gets headlines but seldom gets passed into law.

What can you, the individual physician do to help accomplish our goals? A lot. First, keep yourself informed as to what is going on. Read the JFMA and the other pieces of mail that come across your desk. Tell your associates what you have read. Much of the confusion of last year stemmed from lack of information on the part of many physicians. Second, be sure your county medical society has an effective Key Contact Physician program and an active chapter of FLAMPAC. If it doesn't, help get one going. Most legislation is passed or defeated at the grass roots, in your community, before formal public committee hearings are even held. Third, seek out and make the acquaintance of legislators, businessmen, labor leaders, Bar Association officers and others who have positions of influence. Make your views on these issues known after you have informed yourself on them. And finally, come to Tallahassee, seek out our staff there, and watch your legislators in action, letting them know you are there and interested. This is a very effective way of getting the ear of your home town representatives and senators. They appreciate your interest and trouble in making the trip to Tallahassee.

This committee has, then, nothing to offer but hard work, more time spent away from home, and frustrations along with the successes. There is no magic wand available to solve our legislative problems. But they can be solved with the same kind of diligent application of your talents that you use to care for your patients. FMA needs your help.

John C. Kruse, M.D., Chairman
FMA Committee on
State Legislation
Jacksonville

The First American-German Postgraduate Medical Congress will take place between December 26, 1975 and January 9, 1976 at the Holiday Inn in Nassau followed by a Caribbean cruise. Fifteen qualified University Professors from the United States and Germany, all bilingual, will participate in teaching seminars recommended for practicing physicians, internists, cardiologists, family physicians.

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S. Heyden, M.D.
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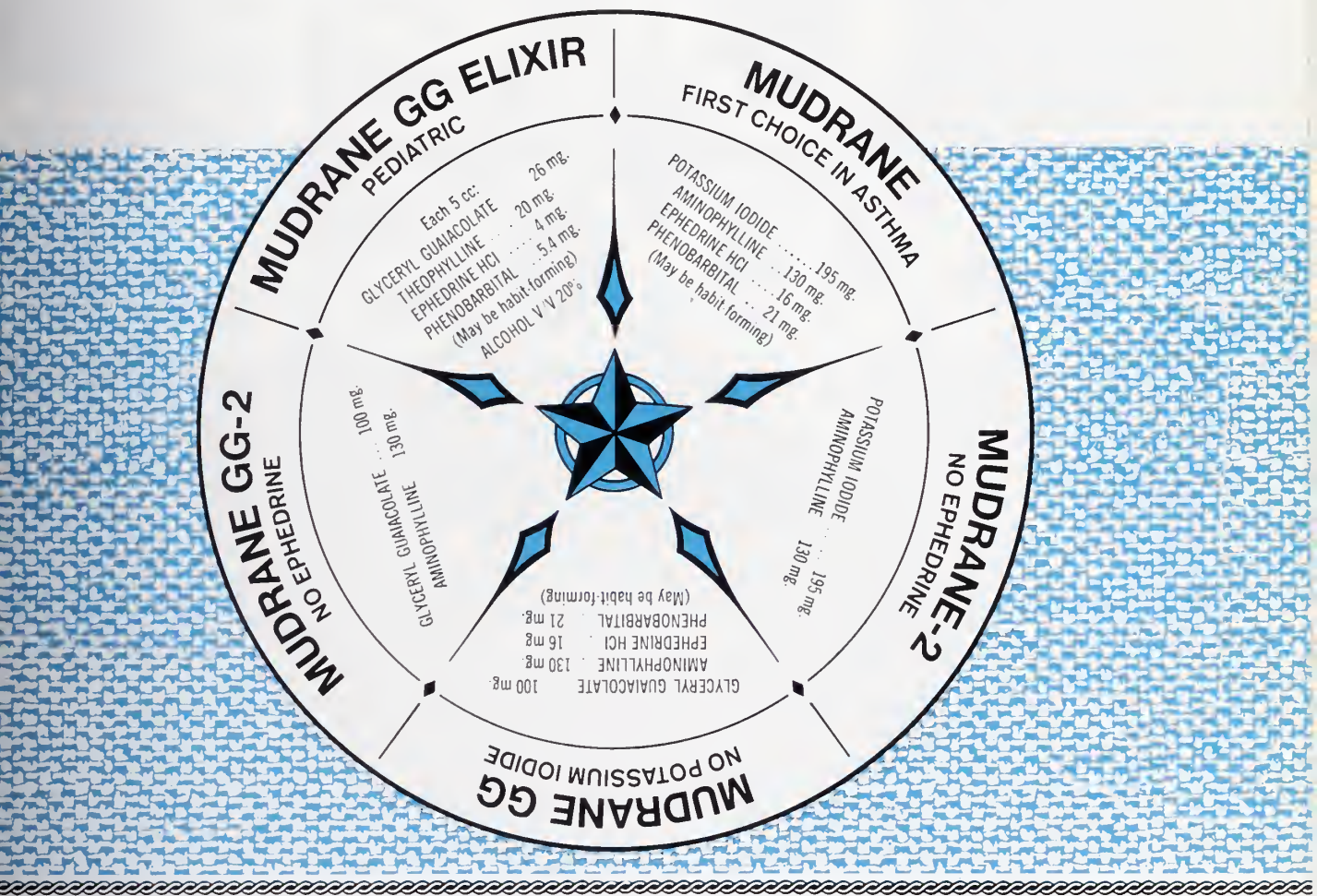

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CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

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Vascular Injury and Repair Associated With Orthopaedic Trauma

MERLIN G. ANDERSON, M.D. AND GILBERTO E. VEGA, M.D.

Abstract: Vascular injuries which accompany fractures or trauma of the extremities need correct and concomitant handling. The rationale of this approach is documented. An examination routine is presented to avoid delayed or inaccurate diagnosis, and surgical techniques for vascular repair are discussed.

The proper management of orthopaedic patients with concomitant vascular injuries requires careful evaluation, prompt and appropriate consultations, liberal use of angiography, and immediate meticulous vascular repair.

Arterial injury not infrequently accompanies fractures in the extremities. Anatomic vascular alterations include arterial spasm, external compression, partial and complete laceration, arteriovenous fistula, and intimal disruption with vascular occlusion.[1] Surgical correction often can preserve and improve the function of that portion of the limb distal to the point of injury. Wartime experiences record an amputation rate of 50% after arterial ligation versus 13% after arterial repair.[2] Injuries among American civilians show that when arterial damage accompanies a fracture there is poor prognosis and that vascular repair greatly reduces frequency of amputation.[3,4]

Recognition of circumstances leading to potential vascular injury, prompt diagnosis, and immediate accurate repair is essential in proper management of patients with concomitant osseous and vascular trauma. The high incidence of orthopedic trauma and the relative frequency of initial treatment if not definitive care which nonorthopedic surgeons must render make it meaningful to review the various facets involved in the pathophysiology, diagnosis and treatment of these lesions.

Mechanisms of Injury

Vessels relatively fixed to adjacent bone are especially subject to injury.[5] In general, vascular injuries are more common with open wounds, particularly gunshot and stab wounds. The brachial and popliteal arteries are most commonly injured. Brachial artery injury is encountered with supracondylar fractures of the humerus or open, displaced or markedly angulated midshaft fractures. Popliteal artery injuries may result from direct trauma, hyperextension of the knee with tearing of the artery or fracture of the bone (femur or tibia) with displacement of fragments.[6]

The subclavian artery may be injured with clavicular fractures and iliac vessels with pelvic fractures. Axillary artery damage occurs with shoulder dislocation and popliteal artery damage with 50% of dislocated knees.[4]

Arteries reportedly damaged during surgical procedures include the iliac during lumbosacral fusion, popliteal during menisectomy, medial plantar with Steindler fascial release, dorsalis pedis during Lambrinudi triple arthrodesis, profunda femoris while nailing or plating the femur,[7] and superior gluteal when obtaining an iliac bone graft. Arterial damage may be incurred while applying skeletal traction,[8] manipulating a fracture, or applying a cast.

Pathology of Vascular Injuries

Arterial injuries are classified as complete transection, partial transection, and those confined

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to the intima. A completely severed artery usually undergoes retraction, constriction, and thrombosis. Partially severed arteries, however, cannot achieve spontaneous hemostasis. They usually continue bleeding, form a false aneurysm or an arteriovenous fistula.

In an apparently intact vessel, the intimal layer can be fractured leading to occlusion. Occlusion occurs by thrombosis, intimal flap formation, or an intramural hematoma forming between the intima and tunica media.[4]

Diagnosis

Concomitant arterial injury is truly rare when compared with the number of fracture cases. The possibilities which lead to its occurrence must be kept in mind continually, however, in order for the diagnosis to be made promptly. Previously it was believed that arterial spasm frequently accompanied fractures. Many patients presenting with this symptom have been found with injury to the intima.[5] Spasm rarely occurs as an isolated phenomenon; usually something else is wrong.

The patient who sustains a fracture and goes into shock should be evaluated for vascular injury.[4] If the artery is transected, diagnosis may be relatively easy based upon the classical findings of pain, pallor, pulselessness, paresthesias, and paralysis.[9] Slow leaks lead to more subtle changes; hence, the injured extremity should be examined at intervals to determine changes in pulses, skin color, temperature, and sensation.[10] A slow leak may lead to pseudo-aneurysm formation; thus, a slowly enlarging mass should be examined for pulsations or bruit.[8]

The Allen test performed at either the wrist or digital level assists in evaluating the patency of the radial, ulnar and digital arteries.[11] To perform the Allen Test at the wrist level, the radial and ulnar arteries are palpated and the examiner prepares to compress them. The patient's extremity is elevated, he makes a tight fist; then the examiner compresses both arteries. Thereafter the patient is instructed to open his fist and the hand is seen to be blanched; whereupon the physician releases either the radial or ulnar artery and observes the flush as circulation returns to the hand. Normally the flush is immediate, and its spread across the hand implies patency of the artery released, and its collaterals. At times, the circulatory picture is complicated by vascular compression and relative ischemia associated with a compartment syndrome. These entities must be differentiated, and when indicated, a fasciotomy may indeed save the limb. Arteriography locates the site or sites of vascular injury and helps select an appropriate approach for skeletal fixation and vascular repair. It usually is reliable but can be misleading in that extravasation may not be present in intimal injuries or small perforating wounds.[5] Arteriography should be performed whenever vascular injury is suspected but clinical findings are inconclusive. Specifically in patients with fractures, arteriography is indicated when there is diminished or absent pulses distal to the site of fracture following reduction of the fracture; a bruit auscultated at the fracture site; a large and/or pulsating hematoma; severe or recurrent hemorrhage through an open wound; and traumatic dislocation of the knee. Angiography may be used intraoperatively to determine results of vascular repair.

Technique of Vascular Repair

The first objective is to restore lost blood volume and the second to control hemorrhage. The latter may include vascular repair.

Once the diagnosis has been made, plans for surgical repair should proceed immediately. Several hours delay may allow distal capillary thrombosis and irreversible ischemic changes. If collateral circulation is adequate, the time interval is less important. On the other hand if the repair is delayed 10 to 12 hours postinjury, then, even though a technically sound arterial reconstruction restores distal pulsations, tissue perfusion usually is not improved.[12]

Anesthesia may be general, spinal, or block. Tourniquet is used where feasible. Several extremities should be prepared in the event autogenous vascular grafts are desired. Anatomic incisions are preferred.[2] Antibiotics should be given preoperatively, during surgery, and postoperatively. Systemic anticoagulation is unnecessary but the vessel lumen should be flushed distally with heparin and saline mixture (1,000 units heparin and 10-100 cc saline). A Fogarty embolectomy catheter can be passed proximally and distally.

Various authors have described the techniques.[1,3,9,11,14] Basically whichever is least traumatizing and restores normal arterial flow is the best procedure for the patient.[10] Small longitudinal lacerations or partial transections sometimes can be debrided and closed primarily. Intimal injuries should be excised after embolectomy or if vessel damage precludes primary closure

without compromising the lumen, resection and primary anastomosis are preferred. At times it is necessary to shorten the bone, stabilize it with plates or rods and then repair the artery.[15] Flexion of a joint adjacent to the site of injury relieves tension on a vascular anastomosis but it must be splinted and the probability recognized of stretching and tearing the anastomosis postoperatively.[12]

A fine grade synthetic monofilament suture has the least reaction for the greatest durability. Large vessels can be sutured with 5-0, 2 mm vessels with 8-0, and 1 mm vessels in the digits with 10-0. These come swedged on to atraumatic round needles of either ⅜ or ½ circle. Suturing with 8-0 and 10-0 material requires magnification; either with loops, lenses or an operating microscope. Everting suture technique is preferable for larger vessels and especially for veins, but end-on coaptation must be used on smaller vessels. Key sutures should be placed diametrically opposite each other and slight traction applied; then the vessel rotated as additional sutures are placed in either interrupted or continuous manner.

While suturing the vessel, its walls should be kept moist with the heparine-saline mixture or a solution of $MgSO_4$; either prevents clotting. Atraumatic vascular clamps and forceps are essential and the vessel must be handled gently at all times. Loose adventitial tissue can be trimmed away. Vein repair should precede that of the artery.

Use of Grafts in Vascular Repair

A portion of a vessel may be destroyed at the time of injury or the vessel wall may be damaged and the vessel become ischemic in that area. If the area is short and the proximal and distal viable portions sufficiently mobile, end-to-end anastomosis is preferable. If the anastomosis is not feasible, some form of interposed graft is necessary. Vascular grafts may be autografts, homografts, heterografts, or synthetics. These are listed in decreasing order of preference.

Autografts may be arterial or venous. Arterial autografts are ideal, easy to handle, have a good take but are difficult to find. Venous autografts are most frequently used because of availability. Homografts undergo degenerative changes. Arterial heterografts (bovine) have good acceptance after treatment with a proteolytic enzyme and only the tubular collagenous network remains. They are then nonclotting on the inner surface, soft, flexible, evenly distensible and have the sewing properties of a human vessel.[16]

Grafts "take" by ingrowth of fibrous tissue (maximum 2 cm in homograft) and by deposition of platelets, fibrin, and cells from the blood stream.[14]

Long-Term Results

After successful vascular repair for acute arterial injury, long-term follow-up arteriograms reveal that about 1/3 became occluded. Following primary arterial repair 18% of arteries closed, after autogenous vein grafts nearly 50%, and following homografts 71% showed late oclusion. Perhaps the vascular repair at least allowed tissue perfusion long enough for collateral circulation to compensate.[17]

Summary

The proper management of orthopaedic patients with concomitant vascular injuries requires: a) careful evaluation; b) prompt and appropriate consultations; c) liberal use of angiography, and d) immediate meticulous vascular repair.

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Cancer Chemotherapy
A Question of Timing

Daniel D. Nixon, M.D.

Abstract: The most difficult decision in cancer chemotherapy is usually not what drug should be used, but rather who needs treatment at what time. This decision is complex and based on such variables as the condition of the patient, aggressiveness of the tumor, effectiveness of the therapy, and ability to monitor the drug efficacy.

The publicity given Mrs. Betty Ford's mastectomy and the decision of her physicians to use "adjuvant chemotherapy" has once more focused on the question of when to initiate chemotherapy in the patient with malignant disease. The decision in Mrs. Ford's case was based on recent data from the National Surgical Adjuvant Breast Project and also European Investigators.[1,2] These studies suggest that the early treatment of subclinical metastases from carcinoma of the breast might allow for prolongation of interval-free periods and inferentially a cure.

In the past many physicians believed that cancer chemotherapy should be reserved for symptomatic patients with measurable parameters by which to assess drug effectiveness. Recently investigators have raised the question whether this approach allows the most effective use of current drugs. It has been demonstrated that early aggressive chemotherapy in patients with osteosarcoma[3] and other soft tissue sarcomas[4] retards the development of metastases after the primary lesion has been eradicated. The use of "consolidation courses" of intensive chemotherapy in patients with acute leukemia already in clinical remission has improved the length of those remissions, probably by further reducing an occult population of malignant cells.[5] The use of chemotherapy in patients with carcinoma of the breast following mastectomy and without gross residual disease is but another example of early therapy producing longer remissions.

The rationale of these studies is based on an increased understanding of the kinetics of growing tumors.[6,7] Experiments have demonstrated that small tumors, which have an increased percentage of cells proceeding through the cell reproductive cycle, are more vulnerable to the current chemotherapeutic agents, most of which are cell-cycle specific. Large tumors have an increased percentage of cells in G-0, a resting phase, and as such are not susceptible to those agents which block DNA synthesis or cell mitosis.

At first glance one might believe that all patients should receive chemotherapy if there remains any possibility, no matter now remote, that all the tumor has not been resected or lethally irradiated. This would direct chemotherapy against a small reproductively active cell population which would be most vulnerable to currently available drugs. In truth several factors must be considered. These include (1) the patient, (2) aggressiveness of the tumor, (3) drug effectiveness, and (4) parameters of measurement.

Who is the patient? Is she a septuagenarian who has recently undergone mastectomy and has positive axillary nodes or a 45-year-old woman with the same clinical picture? Many older patients tolerate aggressive chemotherapy poorly. Decreased bone marrow reserve and general decline in the function of various organ systems make intensive programs such as five drug therapy for breast carcinoma or the therapy of acute leukemia increasingly hazardous. The presence of concurrent medical problems such as chronic lung disease, history of duodenal ulcer, diabetes mellitus, or significant renal impairment invites complications and mitigates against aggressive therapy.

How aggressive is the tumor? The physician should be willing to treat more vigorously, that is,

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subject his patient to an increased risk, if the tumor under attack is of a virulent nature. Significant toxicity might be risked in a mildly symptomatic patient with an oat cell carcinoma metastatic to regional lymph nodes. In this clinical setting there is a 95% probability that the patient will be dead within a year. The same nodal involvement in a patient with a malignant lymphoma, well differentiated lymphocytic type with a follicular pattern, might be associated with prolonged survival with minimal therapy. Severe toxicity would not be justified in such a patient.

How effective is the best treatment available? The currently employed MOPP* therapy in Hodgkins disease produces an initial remission rate of approximately 80%.[8] This program is toxic but its efficacy justifies its use. A similar degree of toxicity would be unacceptable in treating such tumors as renal or esophageal carcinoma with currently available drugs. These produce remissions in less than 15% of patients.

What parameters can be followed to assess therapy? The treatment of minimal residual tumor with adjuvant chemotherapy is appropriate against those tumors which are at least moderately responsive to drugs and where toxicity to those drugs is acceptable.

A different problem is whether to initiate chemotherapy against tumors minimally responsive to drugs which have dangerous or discomforting side effects. This decision may be made on our ability to monitor tumor regression. Objective parameters such as the presence of a pulmonary nodule or the quantitation of a serum monoclonal protein allow the physician to undertake a clinical experiment in which benefits gained by the patient (tumor regression) can be weighed against the toxicity produced. There may be willingness to continue 5-FU in a patient who vomits with each dose, if there is a concomitant fall in CEA. A rising CEA in the same patient would be an indication for another therapeutic plan.

*Drug combination of vincristine, nitrogen mustard, procarbazine and prednisone.

Conclusion

This discussion focuses on several truisms which are often forgotten. The decision to initiate cancer chemotherapy must always be made after consideration of all available data. That correct moment is not a point fixed in time by a textbook but differs from cancer to cancer and patient to patient.

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Virtue is like an angel, but she is a blind one and must ask knowledge to show her the pathway that leads to her goal. Mere knowledge, on the other hand, like a mercenary, is ready to combat either in the ranks of sin or under the banners of righteousness. — Horace Mann

Is It Organophosphate Poisoning Or Mushroom Poisoning?

Case History With Treatment Recommendations

Harry C. Goldberg, M.D.

At 7:00 a.m. on October 9, 1974, I played golf before going to my office. For years I had eaten the nonpoisonous meadow mushrooms often found on golf courses under suitable climatic conditions, especially warm temperatures and high humidity. That morning such mushrooms were unusually abundant and large in size. I ate perhaps a dozen, more than usual for me but not gluttonous either. About one hour later as I drove to work I began to notice tingling in my right hand which was pressed against the car seat and thought it was due to resting my arm too long. Tingling continued despite moving and exercising the hand. Perhaps five minutes later my left hand on the steering wheel began to tingle. I now began to feel apprehensive. Something unusual and as yet unexplained was occurring. An unusual taste sensation developed, limited sharply to the pharyngeal area. It was not sharp, definitely different, but not strongly distinctive, neither pleasant nor unpleasant, surprising more by its distribution than its flavor. I now began to think of mushroom poisoning but could not help thinking I'd never had such symptoms, despite regularly, though only at long intervals, eating the same type of mushroom commonly found in pastures, open fields and golf fairways.

Table 1 gives a brief differential between the poisonous Amanita and the meadow mushroom. Patients with Amanita poisoning remain free of symptoms for the first ten to 24 hours but then vomiting, diarrhea and, at times, convulsions begin. The Merck Manual[4] states mushroom poisoning symptoms may begin within a few minutes to 15 hours depending on the species of the Amanita genus ingested.

There are old mushroom hunters.

There are bold mushroom hunters.

There are no old bold mushroom hunters.[5]

By the time I reached my office, about 20 minutes after onset of the hand tingling and two hours after eating the mushrooms, nausea, vomiting, and diarrhea developed. I knew atropine was the antidote for muscarine poisoning. It was not available at any of several pharmacies I had had my nurse telephone. The hospitals fortunately do carry it. By this time, marked general muscular weakness, bowel incontinence and a chilly feeling developed, and marked leg cramps. I needed to be helped to the car to be taken to a local hospital where, instead of getting a quick injection of atropine, I found myself entered as a mushroom poisoning patient. Soon I did get an IV set-up, two or more atropine injections and a large dose of Vistaril. Fortunately I responded rapidly, fell asleep and on awakening several hours later felt almost entirely well and was discharged the next morning.

The thought of fairway sprays such as insecticides, pesticides, fertilizers, and nematodicides began to occur to me as a more likely explanation of my acute illness. Probably enough organophosphate was present on the mushrooms I ate to cause the poisoning. I spent an entire morning with the local greenskeeper, checking on how and what insecticides, fertilizers and nematodicides are used on the golf course I regularly play on. The greenskeeper (actually keeper for the entire golf course layout) is employed full time there with a substantial crew of persons to prepare and apply these preparations. A variety of organophosphates is an important part of these applications and is indeed in use regularly, frequently, and in large amounts. Extremely tiny amounts of organophosphates are sufficient to cause severe toxicity. Even placing a cigarette on a golf tee, fairway, and putting areas during play and replacing it in the mouth must be avoided. Besthoff states that signs to this effect should be posted.[6] Since the symptoms of mushroom poisoning and organophosphate poisoning are similar in many ways, the cholinesterase test is often useful as a diagnostic confirmation of organophosphate poisoning.

The speed with which the cholinesterase level drops can be more important clinically than the

TABLE 1

	POISONOUS MUSHROOMS[1-3]	EDIBLE MEADOW MUSHROOM[1-3]
		Commercial kitchen table type Psalliota Campestris
Cap	White to green, brown, black	Flesh white
Gills under cap	White	Pink to brown
Ring or annulus on stem below cap	Yes, opens downward	Yes, usually torn
Characteristic cuplike bulb at base of stalk	Yes, opens upward	No

actual level. Workers regularly exposed to small amounts of the organophosphate may have few, if any, symptoms even with blood levels of cholinesterase which might ordinarily be considered dangerous.[7]

Since it is considered that the cholinesterase enzyme is formed in the liver and since mushroom poisoning is hepatotoxic, acute liver damage due to poisoning can lower the cholinesterase blood levels, but probably at a considerably slower rate than the organophosphates.[8] The cholinesterase level in the blood therefore may be expected to be low immediately in organophosphate poisoning and will become low at a slower rate in mushroom poisoning.

Further atropine, although effective against muscarine effects (mushroom toxicity), has no effect on the nicotinic effects of the organophosphates,[9] namely, the previously mentioned symptoms plus muscle fasiculation (spasmodic contractions of groups of muscle fibers giving a visible rippling effect of the skin surfaces), and muscle weakness.

Pralidoxime (Protopam) is an antidote which complements atropine and hastens reactivation of the cholinesterase enzymes destroyed by the organophosphate chemical. The treatment of organophosphate poisoning ranges from simple removal from exposure, in mild cases, to very rigorous supportive and antidotal measures in severe cases.

Death is usually due to weakness of the muscles of respiration and accumulations of excessive secretions in the respiratory tract. Cyanosis must be overcome prior to IV of 2-4 mg of atropine. Protopam[10] 1 gm IV is administered at a rate not to exceed 0.5 gm/min. After an hour a second dose of 1 gm is indicated if muscle weakness has not been relieved.

Protopam need not be given further, although atropine should be repeated and continued at 5-10 minute intervals until the full effects of atropinization have developed, a dry flushed skin, tachycardia (up to 140/min), and pupillary dilation. Red as a beet, blind as a bat, and mad as a hare were our phrases in medical school for remembering atropine poisoning.

Of two hospitals telephoned in Palm Beach County, one, a Florida State Poison Center did have Protopam and the other did not. Of three hospitals checked in the county, none had a record of organophosphate poisoning in the past five years. Only one of the three had a record of mushroom poisoning in the past five years. On the other hand the Hendry General Hospital, Clewiston, in Hendry County, wrote me that in the past five years there had been 15 cases of organophosphate poisoning and four cases of mushroom poisoning. The Clewiston area is the location of large commercial sugarcane farming where large amounts of the organophosphates are used.

Clinical Laboratories of West Palm Beach were good enough to give me information on the number of requests for cholinesterase enzyme. Very few such tests are now being requested, although a few years ago it was more frequently requested than at present. At least one employer did a screening test on work-exposed employees in the past but this was discontinued.

Protection and supervision of workers using or exposed to these agents is important. Complete avoidance is difficult but necessary. Equally, persons such as golfers unwittingly exposed should be informed of the hazards. Children must be protected against contact with "empty" organophosphate poisoning containers.

Atropine is a rapid specific antidote for mushroom poisoning and organophosphate poison-

TABLE 2

	Organophosphate Poisoning	Mushroom Poisoning
History of exposure		
Inhalation	Yes	No
Skin contamination	Yes	No
Unwashed foods sprayed with O.P.	Yes	No
Eating of mushrooms	No	Yes
Onset of acute symptoms	Within 1 to 2 hrs.	From a few minutes to 24 hrs.
Response to atrophine	Good in mild to moderate cases	Usually good in ordinary cases
Protopam	Life saving in patients with severe muscle weakness and respiratory failure	No value
Laboratory cholinesterase blood level	Low	Begins to lower

ing. Atropine does not protect against the severe muscle weakness of organophosphate poisoning. Protopam is necessary for this problem. All hospitals should have Protopam on hand for immediate use in organophosphate poisoning in addition to atropine. Probably this type of poisoning is more frequent than generally recognized. The encyclopedic Merck Manual, 12th edition, has no direct index under organophosphate poisoning but instead it is indexed under parathion poisoning. Although the incident reported here could have been due to mushroom poisoning, the relatively large amount of mushrooms eaten would have caused more serious and prolonged symptoms, whereas the amount of organophosphate present on the mushroom caps probably represented a relatively small amount, yet sufficient to cause the symptoms noted. Regrettably, a cholinesterase blood level test had not been performed.

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Editorial Comment by John E. Davies, M.D., Miami

Dr. Goldberg's article certainly highlights several diagnostic and therapeutic issues that Florida physicians face when confronted with pesticide related illnesses.

Acute pesticide poisonings, of which there are approximately 200 cases annually in Florida, are most frequently due to excessive or accidental exposure to the organophosphorus pesticides. Although in serious cases, atropine and 2-PAM are administered as described in the article, the physician cannot await laboratory demonstration red blood cell and plasma cholinesterase inhibition before starting treatment. Suspect cases should always be confirmed by appropriate cholinesterase determinations. Unipet Acholest test kits are suitable simple screening tests. Confirmation of poisioning is achieved by quantitative measurements of the RBC and plasma cholinesterase by the Michel and pH-stat methods as well as by the specific determinations of the urinary pesticide metabolites by the Shafik et al method. Confirmation of pesticide poisoning has important medico-legal, as well as public health, implications and confirmation can no longer rely on circumstantial evidence or clinical impressions.

There are facilities available in the Pesticides Laboratory, in the Department of Epidemiology and Public Health, University of Miami School of Medicine who can provide accurate laboratory interpretations of suspect pesticide illness.

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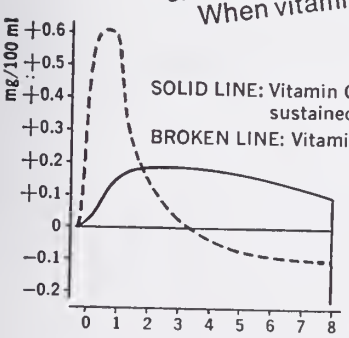

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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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Special Articles

Understanding Family Problems

Jose J. Llinas, M.D.

Abstract: The family is a service organization, probably rooted in the long period of helpless dependency of the human infant. Because of the differing and at times contradictory needs that it has to satisfy, a normal family is beset with a number of conflicts and problems as it evolves its unique historical cycle. Normal and disturbed families are easier to understand when we recognize this process.

The importance of the family as a reference point for all of us can be shown by the usually warm response sparked by words connected with it.

What is *familiar?* The concept has an aura of intimacy and friendship, like a favorite chair or a pair of old, comfortable shoes; of things we know very well, and are fond of and feel at ease with. It is also close and confidential.

Children learn very early that there are certain things simply not talked about outside the family circle. At times, family members tend to become so secretive that this strength becomes a liability.

To illustrate how family loyalty can get in the way, one needs only to think of those pathetic episodes where a grossly neglected or abused child refused to admit mistreatment to outsiders and resisted attempts to be placed out of the household.

Important Concepts

If the physician wants to help a family in trouble, he should have clearly delineated in his own mind the basic components of ongoing family life including the ever-present existence of family conflicts, and the family's own peculiar patterns of communication and need-satisfaction.

Each family follows a clear historical path, its unique family cycle. As this cycle unfolds, there are changed expectations. Early in the family's development providing for the needs of children is fundamental; in later years the problems of the older generation (health, retirement) take precedence.

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Family Conflicts

The family can be understood best as a service organization. It is designed to help the individuals which compose it and the degree of success it reaches can be measured by how good the family is at providing for the needs of each one of its members, without exerting too high a price in its demands for solidarity within the group and loss of individual freedom. This conflict is always present and is at the root of the so-called "generation gap."

Parents have to do more than their share of pushing and shoving to move their children along in their early development when there is a great deal of dependency and unquestioned reliance upon the adults. As the youngsters mature and strive to do more things for themselves, parents have to be able to let go, little by little, and eventually come to accept the young people as adult colleagues. This is a painful process, and the moans and groans it provokes are felt on both sides of the generation gap. As children progress through the various developmental stages, the parents may find that unresolved issues in their own human development come to the fore. A rigid, domineering parent is more likely to experience difficulty with a normally rebellious, assertive 2-year-old. On the other hand, a parent with unresolved identity problems of his own will find the natural highjinks of an adolescent son to be beyond normal human endurance altogether. Whether conflictive issues of this type lead to negative stand-offs or to good natural personal growth in both parent and child probably depends on the strength of the family unit as such, and the community resources available to shore it up at a time of crisis.

Family, defined as all the people living in the same household, comes from the Latin *famulus,* meaning servant. The ideal of service within the family is sometimes bogged down by the chains of servitude. The stage for many of these difficulties is set up by the very fact that all of us as people belong to two basic families.

The first is the family of procreation or sometimes called the family of origin, that is, the parents and sisters and brothers. Depending on the culture, this family may extend to involve aunts, uncles, grandparents and more distant relatives or even servants and friends. The second one is the nuclear family composed of husband, wife and children.

In part because of the great change our country has experienced in the last 50 years, going from a basically rural economy to a more industrialized, urban-oriented society, the importance of the nuclear family has increased while the ties to the family of origin have tended to become less binding. All of us, to some extent, are enmeshed in this dilemma. Should we be loyal to our parents or do we have a stronger obligation to our mate? Obviously, there is no simple answer.

Every year when the holidays come around many families find them a time of stress rather than enjoyment. There is concern about where to spend the free time and with whom. Dormant differences of opinion and conflicts between the family of origin and the nuclear family then come to the fore and create a situation of crisis. This is particularly so when the children in the extended family have not really become independent and have not, as people say, "cut the apron strings." As in marital strife, money becomes an issue if it plays a part, for instance, as a loan or as a gift.

A married woman who had lost her mother in infancy had as a youngster grown very attached to her own father. Since the father was well off, he enjoyed contributing to the financial welfare of his daughter's family. The daughter, on one occasion, felt that she could legitimately call upon her father to provide an automatic dishwasher that the husband felt they could not afford on his salary. The wife could not understand why this turned out to be so extremely upsetting to her husband.

Another couple had taken a loan from the husband's parents for the down payment of their new home. The wife was very resentful of what she felt were strings attached to this loan, in the form of advice about the type of house they should buy and other details of this type. At the same time, she, and to some extent her husband, felt somewhat uneasy about the fact that they were taking advantage of the parent's generosity.

Communication

These examples of family difficulty are part and parcel of everyday family life. They are complicated, however, by the fact that there does not seem to be clear communication among the people involved. When business and family interests are intermingled, it is helpful to make crystal clear what belongs to the one area, and what should be a part of the other. Friendly and open communication is a solid platform on which to build satisfying family relationships.

To communicate means to impart, or better still, to share; to make common a feeling, a piece of knowledge, a degree of understanding. The more relaxed and accepting the atmosphere is within the family group, the easier it is to say what one feels and thinks and believes. Here the confidentiality of the family is a help. It often happens, however, that because telling the truth isn't easy, and people cannot always honestly face how they really feel, there insidiously grows a tacit agreement within the family that there are certain things that are not to be spoken of or talked about. The more areas of this type that a family labels as dangerous and decides not to consider legitimate subjects of discussion, the more difficult it becomes for them to communicate. This forces everyone in the family to prevent himself as well as the others from bringing up the forbidden and by now somewhat sinister subjects.

What happens regarding frank discussion of sexual feelings is a good example of one area where this tremendous pressure can be exerted. Individuals in the family, particularly the members of the younger generation, are forced to ignore feelings and thoughts and fantasies which they possess inside that are quite normal. These natural feelings come to be catalogued as alien and bad and the growing up process of the child is interrupted and distorted.

"Oh, Doctor, I couldn't talk to my mother about sex," said a young teen-age girl. She meant that protecting mother from hearing things that she found distasteful or repugnant had become so strong a need that it forced the patient to distort and arrest her own development and understanding in this important area of her own life.

A 17-year-old high school senior from a rural area was admitted to the hospital after a mild suicide attempt by ingestion of a few sleeping pills. His gesture was motivated by the fact that he had gone to a party with his girlfriend and they had been involved in heavy petting. He felt then that the high moral standards of his very religious family had been compromised and he had no choice but to punish himself. Though the parents were quite relieved to know he had not been seriously hurt in a family discussion later they did agree with the boy that he had indeed transgressed the family's stringent ethical code and a period of atonement and suffering was called for. The exaggerated feelings of guilt and remorse expressed by the young man were, in the parents' view, quite justified.

Satisfying Needs

The human needs for closeness, protection, affection and nurture are so important that in most cultures of the world, whenever people live together in groups, the family as a unit appears. Despite all the conflicts and problems associated with family life, the family endures as an institution on the strength of its ability to provide for the needs of the members. No other social institution seems to do as well in the adequate rearing of children.

This does not mean that as we look at particular individual families, we do not see and recognize weaknesses and defects in their structures. All families face, at one time or another, threats of dissolution. There are factors from outside and problems from within, summarized in the conflicts that we have mentioned before. It is perhaps also symbolized in the old truism that when people are married, they often think of the advantages of being single and when they live alone they envy others what they then consider the joys of family life.

Probably one of the most important factors making the family so enduring is the long period of dependency of the human infant. Children need adults to take care of them or else they won't survive. This long period of closeness, intimacy and dependency upon another human being has lasting effects on the life of the individual. Out of this long period of dependency, a very peculiar psychological and social barrier develops. It is probably basic to the development and growth of families, and without it family life as we know it in most societies would probably not exist. The anthropologists call it the incest barrier or the incest taboo.

The prohibition of having sexual relations, which is thrust between and separates members of the older and the newer generation, makes it possible for the younger group to become independent and eventually start new families. A number of customs and rules of morality which designate the appropriate behavior of family members towards each other is weaved around the incest barrier. These regulations become at times quite constraining, perhaps because at one point they were thought to be basic to the survival of the family, and the society of which it is a part. For instance in an agrarian economy where land ownership is important, the authority of the father as head of the family and controller of its subsistence is naturally greater than in an industrial society, where the younger generation does not depend on the good will of the elders to obtain employment and, in fact, has a variety of opportunities outside family limits.

More commonly, there is a resistance to change that interferes with enjoyable family life. Blind obedience of children towards their parents has perhaps a necessary value for the very young child, but to expect and even demand this type of relationship from an older youngster is damaging both to the child's ability to take charge of himself and to the acceptance of a more reasonable paternal authority, based on experience, wisdom and love, rather than on forced compliance.

A 41-year-old contractor, plagued by severe feelings of depression, described a very unhappy early relationship to his father, a tyrannical and abusive person who "ran his children with an iron hand." Despite the fact that the patient had mixed feelings about this approach, shown among other things by his inability to provide adequate leadership and guidance to his own children, he, early in his therapy, claimed to be "grateful" to his father for the sadistic beatings he had received, "since they have obviously not caused me any harm!"

Changing Functions

Throughout the centuries, as social groups become larger and more complex, many of the at one time very important functions of the family are taken over to a large extent by other social institutions and organizations. The provision of health care, protection of life and limb, and education of children are examples of this pervasive trend. The family still has a strong impact in many of these areas; in some others, as our society becomes more knowledgeable and sophisticated. it comes to play a more important and more basic role. In the civilized modern world, the family unit, particularly as a nuclear one, has become the basic social instrument for the enjoyment of tenderness and affection between the parents, and for the care and development of children.

This separation of functions between family and community, with many closely interphased areas, is at the root of some problems. How much freedom should families be allowed to mold the personality of their younger members and fulfill the adult needs of the older ones? Increasing difficulties apparent today, such as the proportion of child abuse cases, which has been called by some "epidemic," the rising incidence of divorce, illegitimacy, and some forms of delinquency, are examples of many of the unresolved problems in this area.

A very practical consideration is the fact that, paradoxically enough, many people usually go

about the business of seeking a mate to create a new family precisely in the adolescent period when they are still struggling to break the binding emotional ties to their own original families. Should it surprise us that so many so-called juvenile marriages do not make it?

Perhaps a more amazing fact is that so many more marriages do stay together and develop into stable, enduring families and that the transmutation of the primary loyalty to the family of origin into loyalty to the new nuclear family can occur without great upheavals. Expanding waves of affection and respect can then ripple into the confines of two, three or more generations.

Early Marriage

There are young married people who, for a variety of reasons, decide to stay "home with the folks." Or if they start a household of their own they settle not too far from where their own families live. Many times, of course, this indicates unresolved dependency problems and it accounts for a fair share of the unhappiness that we find in troubled early married couples.

These beginning years of marriage are by definition a situation of crisis because the young people need to get to know and grow accustomed to each other. Some of this is accomplished throughout the courtship but as we hear from our patients time and again, "You never really know people well enough until you have to live with them." Developing a shared sense of intimacy is an accomplishment that, even for people who deeply care about each other, is not an easy task. Some accommodation to the basic differences in masculine and feminine psychology has also to be reached. Many serious decisions have to be made, including the one regarding further growth of the family. Are we to have children or are we to wait?

As always, once a new situation beomes familiar, there is a degree of disappointment. Marriage may not be all that it was expected to be quite independently from the absence of any serious problems. The wife's strong need for a baby, for instance, may come into conflict with the husband's equally strong ambition to further his education. Then, if the young couple adjusts to some of these demands, as their needs change, new strains are added. Nowadays, divorce occurring about the time the husband finishes his training or a few years later when he is becoming reasonably successful in his career is many times the result of an impossibility to shift into new roles and changed expectations.

Children

If the couple decides on having children, a true family life pattern develops with as many new satisfactions as added responsibilities and increased strain. Conception and pregnancy force them to adjust to physical and psychological changes, primarily involving the wife, but in reality affecting both spouses.

Delivery and the early months and years of the infant's life try the parent's resilience and ability to cope with new and at times seriously overwhelming demands. Not only must each manage with less personal and intimate attention from the other but they have to dedicate new and vigorous efforts to the care of the offspring.

Fortunately, just as we see youngsters going through different stages in their path to maturity, parents also grow and develop as caregivers as their experience increases.

"With my first child," a witty mother said, "I used to go running to him every time I heard a small noise. With my fourth one, I pretty much have to sense that the whole house is breaking down for me to run to wherever he may be." In the normal family, this sense of expanding competence and maturity has a beneficial influence upon the husband-wife relationship. A much more comfortable situation develops and there is more enjoyment not only of the children but also of each other as adults.

As the children grow older and their school life takes on added importance, there is a renewed sense of freedom particularly on the part of the mother. She now has more time than she ever did before and it can be used constructively and creatively or it could be part of the uneasiness and sense of failure which probably reaches its peak in middle age with the so-called "empty nest syndrome." What this essentially means is that the mother feels unneeded and many times unwanted, fearing that she has very little to contribute to the lives of others. The husband may experience feelings of the same type, particularly as he sees that he has reached the culmination of his advancement in work or in some other area of life.

Late Years

The best answer to many of these problems is, of course, prevention; to prepare oneself and be ready to face the new challenges when they arise. A woman who has neglected personal interests throughout the years of bringing up her children

may find it very difficult to become reinvested emotionally in things that she enjoyed before. The man who has worked very hard all his life and has limited outlets for recreations or outside activities may realize when he retires that he isn't really "interested in anything."

As part of a family of origin, elderly married people have to cope with the problems in the relationship to their now adult children. The enjoyment of the new and very satisfying role of grandparent is one of the assets in this period of life for those fortunate enough to have reached it. Grandfatherly feelings and concerns are one of the few conflict-free areas of contact and enjoyment between the two families. As the old folk's authority and functions ebb away, their grandchildren are the crest of a new wave, and the seemingly eternal cycle of family life begins again.

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Others Are Saying

Let's Hold To The Standards

I know we need more doctors and nurses in Florida, but I fail to see the benefit of lowering our standards to get them. I am referring to the recent practice of allowing graduates of foreign schools of medicine and nursing to take the examination for licensure written in their native language. According to a recent ruling if there are five or more applicants who wish to take the examination in a language other than English the board will provide and grade the papers in that language.

I can see only a limited benefit in this situation, if an applicant plans to practice in an area where that language predominates to the exclusion of English or if he plans to return to his own country.

Furthermore, I see the possibility of inflicting on these people a second rate quality of medical care unless the board is able to insure that the standards of training are equivalent to that of our American schools.

If they are certified in a non-standard language will we maintain inspection in that language or trust to luck that they will retain their proficiency. I would feel insecure in knowing that my own orders or prescriptions were subject to translation and interpretations before being administered to the patient.

If a doctor or nurse wishes to be qualified to practice in this country it seems that the least he or she could do is to obtain a good command of the English language. After all they will be practicing American medicine on United States citizens who understand the English language.

This is not intended to degrade or slander the many well trained foreign born or foreign graduate colleagues who practice with us. I surmise that a poll would show that many of them feel the same about the standards. After all, they have met those standards and have a right to pride in their accomplishment.

Finally since we have a standard that has produced a quality of medical care that we can be proud of let us not lower our requirements, but LET US HOLD TO THE STANDARDS.

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Historical Contrasts in Medical Education

With Particular Reference to Internal Medicine

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Abstract: Much has happened during the past 75 years, and particularly in the past 25 years, to change the settings, directions, social demands, student involvement, and interests of faculty in schools of medicine. In many respects these changes have markedly improved medical education, scholarship, and patient care, but they also have had important effects which are necessitating additional change and placing great stress upon medical schools. Recognition of the contrasts between medical education today and in the recent past is required to appreciate the rapid and important changes that have occurred, to accomodate appropriately, and to perceive what must be done to adapt and prepare for the future.

Twenty-five years ago medical schools seemed less complex and burdensome. Clinical instruction was dominantly provided in hospitals for the indigent. Teaching services in hospitals were less likely to be centers for referral of patients with complex, complicated, and exotic diseases. General medicine (primary and secondary care) was predominant. Housestaff and medical student involvement in making policy and planning was limited. There were few full-time faculty. Social pressures upon medical schools to meet health needs were less and those completing training were less likely to be specialists in one or another field of medicine.

Today, teaching programs have increasingly developed in settings providing private patient care. Income derived from patient care is becoming a progressively larger portion of the economic base for medical schools. The number of full-time faculty has increased markedly and they have greater specialty, rather than general medical, interests. Housestaff and medical students have become increasingly involved in and vocal about their training programs. Medical schools are increasingly called upon to meet society's needs for health care.

Discussion of these historical contrasts may seem unimportant to some, but others, hopefully, will see a perspective useful in examining present problems, deficiencies, and strengths in medical education, and visualize what needs to be done to resolve these deficiencies and problems, and to add to existing strengths.

Hospitals

With few exceptions, medical school teaching hospitals, up until recently, were community hospitals for the poor or medically indigent, or involved "public" wards of university or other hospitals. Experiences on private medical services were usually considered "inferior" to the public wards as delegation of responsibility to the housestaff was more difficult, and the patients were often "less interesting." Outpatient responsibilities were almost exclusively in the "public" clinics, and emergency rooms served almost entirely for care of the poor and medically underserved.

"Public" clinical services presumably provided primary and secondary care for a community population which was largely, if not entirely, impoverished, had limited resources to meet the costs of medical care, and these costs were assumed by the hospital or by some form of public assistance. Most physicians in practice or on the faculty of medical schools today obtained their training in such settings. Undoubtedly, it influenced their attitudes towards teaching and patient care. Acceptance of responsibility for patient care in this setting by faculty or teachers was minimal, and their role was to provide instruction and only indirectly to provide care for the indigent patients as this was largely done by housestaff. Training in this setting was considered good, as it provided maximum opportunity to assume responsibility. Patient care in centers with good housestaff probably was satisfactory, but

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continuing care was poor, except for patients who were considered "good" teaching cases. Although the concept of comprehensive care was intoned, this was accomplished largely by having available a number of different clinics, which could be called upon to treat particular patient needs. In fact, it is questionable whether this was or now can be interpreted as comprehensive patient care. It was episodic care by many different physicians, each of whom usually cared for one aspect of the patient's problem. The general medical clinic often was thought to be the coordinator of patient care, but progressively became merely another source of care and not the focal point of care.

Advances and improvements in technology, and the specialized facilities and staff of teaching hospitals have changed the educational and patient care setting dramatically in recent years. These hospitals now are usually staffed by highly skilled and trained physicians in special areas of medicine and provide facilities leading to their becoming centers for the care of patients with complicated and complex medical and surgical problems. Increasingly, therefore, university teaching hospitals have become tertiary care centers. This optimally uses their facilities and staff but alters materially the milieu for education of medical students and housestaff. The tendency has been, in some such settings, to mold the educational programs to the teaching hospital, providing increasing exposure of students and housestaff to referral patients, and to a highly competent and specialized staff. Unquestionably, this has increased interest of students and housestaff in uncommon, albeit important, medical problems, but may have distorted their appreciation of problems patients experience outside the medical center. For example, students and housestaff in internal medicine trained in a university hospital today may perceive and believe that every patient with hypertension should be investigated with measurement of catecholamines, renal arteriogram and other sophisticated diagnostic procedures without recognizing the limited and narrow spectrum of patients they see during training, many of whom represent therapeutic failures or unusual problems. Similarly, those in training often have more experiences with and understanding of *Pneumocystis carinii* infection than with streptococcal pharyngitis or cellulitis. They may look upon every patient with recurrent boils as a problem of granulomatous disease and not recognize the factors usually predisposing to boils as they occur in the general population.

The changes in many teaching hospitals in the past few decades have been useful in improving the depth of understanding in biomedical sciences of those in training. Certainly, it has been effective in providing training for those pursuing careers in specialty areas. This has also probably affected the career patterns of physicians toward specialty work.

A question requiring attention is "Should teaching hospitals, as they have developed as centers for care of complex, complicated, and often infrequent diseases, be the principal or only setting for training of physicians?" Perhaps other settings for medical education are required.

Public vs. Private Patients

A form of national health insurance available to all is evolving inexorably. Increasingly over the past several years "third party" payments for medical services have provided protection for many of our citizens. The Veterans Administration makes available resources for the medical care of a large proportion of the male population and may begin to provide health care for families of some veterans who have limited or no other health resources available. The U.S.P.H.S. provides medical care to the Indian population on reservations; the military services provide health care for a few million military personnel and their families. Add to this the services provided through employers, labor unions, publically supported sanatoria, and other types of institutions and the large proportion of our population now eligible for financially underwritten medical care can be more fully appreciated. The emergence of Medicare and Medicaid a few years ago provided resources to meet the health care needs of the elderly and the poor. Presently, the legislative and executive branches of the U.S. government are nearing agreement on some form of National Health Insurance available for all or most Americans. Like it or not, the means for meeting the cost of medical care are changing and will change further and more rapidly in the future.

As "third party payment" for medical care has become available, patients who formerly were dependent upon charity of hospitals and public assistance often are now able to seek and obtain private patient care. In addition, the availability of sources of funds to defray the costs of medical care for the poor has been followed by decreased willingness of communities to subsidize community hospitals and public services in teaching hospitals. These events have led to the progressive termina-

tion of community financial support for charity or public hospitals. The changes in many public community hospitals during the past few years are likely to increase in the next few years and are raising questions about the viability of such hospitals for patient care and teaching unless they become institutions attracting patients seeking private medical care, now that such private care is becoming possible for all.

Agencies paying physicians for personalized patient care insist, rightly so, that such payments are not warranted if the physician merely functions as an instructor of housestaff and assumes no personal responsibility for patient care. The former traditional role of the faculty in a teaching hospital, therefore, has had to change or reimbursement for physicians' services may not be allowed. If payment is to be provided, the physician or faculty must demonstrate their function as personal physician to the patient, and this may deeply intrude upon the responsibilities previously assumed progressively by the housestaff.

The faculty of many teaching hospitals face a prominent dilemma. They desire and need the income from professional services for patient care to maintain the medical school's fiscal solvency and their personal affluence. Therefore, they have increased their involvement in patient care and have at the same time altered, sometimes materially, the progressive acceptance of responsibility for patient care by housestaff, affecting an important key to professional training. In addition, medical school faculties have spent increasing amounts of time in collection of professional fees for patient care, often to the detriment of the time which might have been devoted to evaluation and improvement of educational, scholarly, and patient care programs.

The problem of medical schools in making the transition from providing education largely in public hospitals to development of effective educational programs in private hospitals has not been resolved. Imaginative leadership is required, but certain essentials must be kept in focus: (1) excessive emphasis upon professional fees as a source of income to sustain established academic programs and to develop new education programs is fraught with danger to the medical school's mission; (2) increased involvement of faculty in personalized patient care may improve educational and patient care programs but may also reduce important components of training, unless properly balanced; (3) acceptance of the principle that medical care by a personal physician should be available to all is meritorious and should be inculcated into our educational programs but this will influence medical teaching services; (4) we must recognize contrasts in teaching hospital settings today with those in the past and need to assess the adequacy of many present teaching hospitals as the principal and only setting for medical education.

General Medicine vs. Specialty Medicine

Over 25 years ago the full-time clinical faculty of Departments of Medicine were very few in number; most were accomplished general physicians with some interest in special types of medical problems and participated eagerly in the general medical programs of the medical school and hospital. Specialty divisions of these Departments either were nonexistent or limited to major health problems such as tuberculosis and venereal diseases. Specialized patient care units, with the possible exception of units for communicable diseases, were nonexistent. Much of the housestaff and student teaching was provided by practicing physicians who were members of the volunteer faculty. Few persons were receiving training beyond the residency level in special areas of medicine.

Most Departments of Medicine today have almost every organ or system of the body represented by a specialty division composed of a few or many highly trained and competent specialists. General medical services in many teaching hospitals are being eliminated or reduced to make way for specialty services, to provide for the interests of the departmental divisions and their specialty programs. Contrasted with the past when it was often considered a privilege to have opportunities to attend and teach on general medical wards and clinics, now this activity is often avoided as much as possible, and faculty shun responsibility for a general medical clinic, as they are often heavily committed to a large consultation or inpatient and outpatient service in their area of specialization. It seems certain this trend will continue in order to optimize care for patients in teaching hospitals providing for complex or complicated special medical or surgical problems.

Unquestionably, students and housestaff trained in teaching hospitals with specialized staff and resources have an outstanding opportunity to become familiar with current developments in

biomedical science, acquire vast knowledge about diseases, and become skilled in diagnostic and therapeutic techniques. The role models provided by the faculty in such teaching hospitals, however, are not often applicable to the careers of most trainees who will become practitioners of medicine in communities of varying size, most often without medical teaching programs. Pursuit of training to replicate these role models usually leads to specialty training, and trainees often hope they will have a dominantly consultative and specialty practice. This may be partly responsible for the finding that almost 2/3 of those in graduate medical training programs are in specialty rather than general or primary medical training. To this must be added the fact that 80% of graduate medical education is now provided in university hospitals.

The contrast between the medical care programs in university hospitals two decades ago and now as reflected by the changing emphasis upon specialty and general medical care and training is obvious. Without meaning to indicate the good or bad of this change, it nevertheless has had an important impact upon educational programs, the aspiration of trainees and the medical care available to the public. Future decisions affecting the trend toward specialization, whether encouraging or discouraging, will profoundly affect schools of medicine even more than at present. Medical faculty should responsibly examine what has happened, where we now are, and where we hope to be in the future. Teaching hospitals now staffed by highly trained specialists and serving as tertiary care centers probably should continue this development and serve principally for training in their areas of interest and ability. Then other patient care settings and faculty must be developed or expanded to provide greater training opportunities in general medicine or primary and secondary medical care.

Housestaff Involvement in Policy and Planning

The changes in stipends for housestaff during the past 25 years have been striking. Previously compensation, except for room, board, and laundry, was not provided or was meager. Today, stipends are in some instances handsome, but at least adequate to meet all or most living expenses. This change has been commendable but also has been associated with other changes which are of questionable value. Are housestaff hospital employees or trainees? As salaries increase and as housestaff demand the benefits, job security, and other rights of employees, their training role and privileges may alter. Hospital directors, university administrators, and faculty may perceive the housestaff as employees, hired to provide a particular service, and not as students in training. If, added to this, housestaff perceive themselves as employees rather than as students privileged to have opportunities for training, irrespective of the necessity to pay them adequately for the services provided, the character of graduate medical education as it has been known and valued may alter. Now, most housestaff in good teaching centers participate in programs to provide them with experiences most likely to prepare them well for particular professional careers. This includes rotational experiences in different patient care settings, elective opportunities to meet personal interests and needs, structured conferences and seminars, the teaching efforts of the faculty, and the understanding of patients. If housestaff employee demands, rather than training demands, are progressively emphasized, the privileges for elective work and the training character of their program may decline, their numbers may be reduced and they may be obliged to serve at the discretion and direction of the hospital administration to meet hospital rather than training needs. The Orwellian possibilities of this change may be pleasing in terms of the economic aspects and efficiency of hospitals, but are disquieting in terms of their impact upon graduate medical education and the future of health care. Housestaff, faculty, and administrators should recognize the implications of further emphasis upon the employee role of housestaff to protect the great importance of graduate medical education in training physicians. Housestaff should not be indentured servants as they once seemed to be but also should not be only well-paid servants or employees. Their student or trainee role, privileges and opportunities must be protected.

Recently, a practicing physician who had had no contact with graduate medical or housestaff education for 20 years visited me while I was meeting one morning with our residents. The housestaff were voicing complaints about housekeeping, nurses, clinical laboratories, radiology, and other aspects of the hospital related to their activities. I was the focal point of their displeasure, served as a sounding board for their complaints, and was expected to deal effectively and quickly with their problems. Afterwards, the physician visiting me was aghast that the residents had spoken so openly to the Chief. Of

course, this has become a common experience for the director of every housestaff training program, and is good. The former passivity of housestaff to inadequacies in patient care and support services has rapidly given way to aggressive concern and action. Housestaff now rightly expect to be heard and to have a voice about inadequacies in their program as they see them. They are, after all, constantly on the "firing line" and can identify problems requiring remedies long before the faculty, who often have a "behind the lines" perception of the hospital. Similarly, housestaff now expect to be involved in developing policies which affect their activities and may loudly oppose new programs which may appear to appease social pressure and exploit their availability to meet responsibilities belonging legitimately to others. Frequently, involvement of housestaff in planning and policy formulation assists greatly in remedying inadequacies in patient care and improves training programs. Their counsel and advice should be sought and this can facilitate necessary change. Adversary relationships between housestaff and directors which too often have surfaced, however, should be avoided. Polarization of positions and failure to balance personal interest with institutional objectives, as frequently has occurred, has been destructive in some instances. Educational programs in the long run will suffer if large objectives and goals are not identified and dealt with positively and constructively. Part of the educational purpose is to facilitate development of means and methods of constructive action to improve patient care, improve programs and remedy inadequacies. Housestaff now more than ever before, and increasingly in the future, must become partners with faculty, administrators and patients in the advancement of good patient care and protection of training opportunities.

Medical Students and Relevancy

During the past two decades clinical faculty of medical schools have become increasingly more involved in biomedical research and the rewards for this effort were considerable in terms of academic opportunity, advancement, recognition, and financially. A decade ago medical students began to state loudly: "When are you going to get a faculty interested in teaching clinical medicine and willing to leave their research laboratories to provide 'relevant' instruction for us to become doctors?" Vocalization of this concern by students, awareness of the problem by many faculty, and recent difficulties in obtaining the financial rewards associated with biomedical research have led to major changes in educational programs for medical students. Many faculty have spent hundreds of hours discussing, arguing, planning, and revising curricula. Pressures have mounted to eliminate the "unessentials" and reduce the required years of training. Clinical faculty have become more and more involved in preclinical "basic" science teaching. Basic science departments have often felt threatened. Some school administrators have drastically revised their estimations of the importance of biomedical sciences and research in the medical school. The changes in the past few years are still rapidly evolving, and it is impossible to determine what will evolve in the future. The changes which have occurred, however, have had profound impact upon medical student teaching.

Medical students have been increasingly involved in planning, formulation of policy, program implementation and evaluation in recent years. This has been valuable, but students have certain limitations which require their impact to be placed in perspective. The interests and concerns of freshmen are not always the same as those of juniors and seniors. Students are in medical school usually for less than half of their total period of medical training. It is difficult to identify students truly representative of their peer group, as the hierarchy among students is class to class and representatives of a single class are more likely to reflect personal rather than collective views.

The variability and changeableness of student views is illustrated by attitudes about grading. Before recent times, students accepted grading systems and their educational programs as inevitable and planned by their faculty as necessary for their development. More recently, grades, examinations, obligatory class attendance, competition, and other aspects of the educational program of medical schools have been challenged, questioned, and overtly opposed by students. Plastic responsiveness to the students' pressures often occurs in the zealousness of faculty and administrators to be "in touch" and "in tune" with student needs. At times, readiness to change when students present demands leads to humorous pendulum strokes. One year, grading may be abandoned and a pass-fail system established, only to be changed the following year upon the demand of seniors that grades should be given to provide the information needed in applying for an intern-

ship. This may precipitate reestablishment of a grading system, and so on and on change can occur yearly or every other year. In the past seven years at the University of Florida, we have been through four such cycles. Hopefully, the faculty now appreciate the changeable character of students' wishes, and recognize the need to develop an equitable system (even though not approved by all) and provide some order and stability.

Students 25 years ago voiced and displayed far less concern about social issues than has been demonstrated by students in the past few years. An amazing number of programs have been developed by medical students to provide health care for those in need, often with little support, and occasionally objections, from their faculty. Fortunately, students have frequently been persevering and have inaugurated efforts which faculty and practicing physicians have subsequently found "worthy" of their support and involvement. Amazingly, yet pleasingly, in our school a student-developed community patient care program begun over four years ago has become incorporated as a part of the school's educational program and continues to be as enthusiastically supported by the students today as in the beginning, even though the initial planners have graduated and moved on. Such evidence of social action by medical students has been one of the more exciting changes in medical education, but cannot be attributed to the school's educational program. More often it is a reflection of changes in society. Nevertheless, the students have shown the way to social action by medical schools and have pulled faculty into programs they otherwise might have avoided. These events justify as much as any other the reasons why involvement of medical students in formulating policy, planning and implementation of programs in medical schools is important in providing new insights and thrusts.

Faculty

One of the most dramatic changes in medical schools during the past 25 years has been in the clinical faculty. Their number has strikingly increased; their interests in research, often with limited or little relationship to clinical and teaching responsibilities, have increased; their degree of specialization has become even greater; their dependency on extramural and intramural financial support has changed; their salaries have become more nearly equivalent to those of practicing physicians; their institutional allegiance has changed; they have become progressively more mobile; they have become subdivided into increasingly numerous and often independent units, altering markedly the role of the department and its responsibilities.

As mentioned before, much of the teaching and supervision of patient care 25 years ago was provided by volunteer faculty composed of practicing physicians. Progressively, the number of full-time faculty has increased and the involvement of volunteer faculty in the educational program has decreased in many medical schools. This often occurred with no significant increase in number of teaching beds, a modest increase in number of students, but a progressive increase in housestaff and an almost logarithmic increase in number of postresidency fellows in advanced clinical specialty training or in research. Such growth in numbers has been necessary and valuable but has had profound influences upon faculty relationships, programs, responsibility, and teaching.

The increase in clinical faculty over the past two decades was very much related to the progressive increase in public funds, largely through the NIH, for support of research and research training. These funds provided the resources for faculty salaries, fellowship stipends, building of facilities, support of personnel, development and purchasing of increasingly sophisticated technical equipment, travel for participation in scientific meetings, and recognition of accomplishments. The importance of these funds in furthering understanding, diagnosis, treatment and prevention of disease would be difficult to catalogue or define, but they profoundly altered the priorities of faculty for personal research, teaching, patient care, and institutional development. Many faculty were able to obtain their own funds. These added to the growth of the institution, but investigators became independent of the institution for their support and rewards. The NIH and specialty societies gained the faculty's allegiance, although most faculty contributed to institutional needs. These needs were met often reluctantly and not accepted as prime responsibilities. The Chairman of Departments encouraged such developments, and from the eminence of their faculty's efforts often gained positions of prominence and respect, but also had limited authority and could command less and less of the faculty's efforts. This pattern still prevails but is changing visibly. With diminution of extramural support for individual faculty research and training activities,

they are having to turn to the medical school and department for support and security. Such support is limited and faculty feel increasingly insecure and are having to alter patterns of activity and allegiance. Some have been disillusioned and entered private practice or sought what may appear to be a more secure position elsewhere. Many have been angry and frustrated, often expostulating disappointment with the Chairman of the Department, Dean, Vice President, University, Board of Regents, legislature, federal government, or have explained their situation because of presumed "anti-intellectualism" throughout the land. None of these positions has materially improved the faculty's lot, restored the former halcyon days or developed the approaches necessary to build, grow and develop in the future. Some faculty have been fortunate, and by virtue of established achievements before the days of limited affluence, have continued to acquire extramural resources to function as before. Too often those who are fortunate are critical of others without such resources who are accused of limited academic capability, and the difficulties of those who have been attempting to achieve academic distinction and acquire extramural resources in the present times are not fully appreciated. This attitude also is occasionally responsible for provoking dissention, jealousies and unbalanced growth of the institution.

Faculty have had to adapt to changing demands for them to provide personalized patient care to obtain the income for their salaries and other resources, often in a setting where such funds previously could be used for fringe benefits and new program development. These fringes and new programs are still desired and needed, but what was cake before is now bread and butter and is increasingly required for fiscal solvency. Perhaps unfortunately this has resulted in excessive expenditure of time to see that all patients pay, that fees rise and charges previously overlooked are now billed.

Faculty have increased their patient care activities and this has often diminished their opportunities for scholarship and teaching. Clinical teaching requires time and this limits the number of patients which can be cared for. Systems have been proposed to provide incentives to faculty to increase their commitment to patient care, often to provide salaries equivalent to those of practicing physicians, or more. Once this develops fully, many faculty will increasingly question why they should accept the difficulties of working in an academic setting with administrative and teaching duties when they could do the same more comfortably in private practice. This could have profound influences upon faculty scholarship and teaching.

The increasing dependency of faculty upon institutional support, however, could constructively reestablish the faculty's institutional allegiance and this, in time, could further the mission of students, scholarship, patient care, and the institution. One thing seems certain—those who remain in academic life today will increasingly do so because of an appreciation of the values of academic life; the most valuable items being time to learn, time to think, time to study, time to investigate, and time to teach.

Social Pressure

Medical schools are instruments of society to train individuals who can care for the sick and prevent disease. During the past 25 years they also have become instruments of society for research directed towards improving human health and well being. They also serve to provide patient care, opportunities for faculty development, and medical leadership. They are not instruments solely developed to meet the interests of faculty and students, except as their interests may contribute to the large objectives.

In the past, medical schools provided patient care mainly to the poor, and society accepted this as a mission of these schools, and it served the school's purpose rather well. Today, as has been mentioned, university hospitals serve as one of the resources for specialized medical care and less and less often serve to give care to the indigent. In fact, they are increasingly expected to pay their way by providing care to patients who can pay for medical services. These trends, I do not believe, will change, but we must examine carefully whether or not they are consistent with the school's major purposes, or how they should be influenced to prevent distortion and possible destruction of the medical school's mission in teaching and scholarship. In a sense, social pressures are forcing medical schools in directions which may have and possibly has adversely affected the reasons for their existence.

Twenty-five years ago medical school faculty were the principal leaders in charting social objectives in medical schools and health care, and this resulted in the marked growth in biomedical sciences. Today, nonmedically trained persons, including politicians and others, have been chart-

ing the path for medical schools and health care. Too often the faculty, as the AMA before it, has been acting defensively and developing counteractive forces. No one is better able to identify health needs and future medical possibilities than the medical profession, but faculty have too frequently not demonstrated the vision or exerted the constructive effort to provide leadership in meeting the important health and societal issues of today. Rather than moving defensively, therefore, medical schools have recently and must now actively assess their social responsibilities, identify means whereby they can effectively and positively meet social needs within the limits and scope of their academic mission. The social pressures exerted upon medical schools can be constructive rather than destructive, if followed by appropriate responses and acceptance of new responsibilities. Otherwise, society will seek resolution of health problems as it perceives them, even if this requires establishment of programs outside the medical school or by fiscal and other pressures upon the medical school. We must respond to the challenges that are constantly emerging and changing. Transitional periods in medicine are not new; they always are with us, but the call to action stated 35 years ago by Sigerist has yet to be dealt with effectively. "There is a great deal of unrest in the medical world as a result of this paradoxical situation. While some physicians are fully aware of the trends of the time and have the courage to face the problem openly and to seek its best solution, others are afraid of any change. They look back to a past that is gone irrevocably. Trained as highly specialized and efficient scientists, they are unprepared to grapple with problems that are primarily social, personal and economic. They have built for themselves a legendary, sentimental and romantic history of their profession to which they cling desperately and which determines their actions."

Today, there is effort to change to meet our social responsibilities, and this is encouraging. Adding these new responsibilities to old ones which are essential, balancing those which are important and carried from the past with those which have yet to be met, and building on past and present strengths and victories to achieve new vistas of excellence and meeting larger purposes is the task. Vision, foresight, courage, vitality, and institutional, or collective faculty effort, is required. Our sights must rise from the seemingly critical but really mundane crises of the moment to find the possibilities which can and must be developed and built for the future.

▶ Dr. Cluff, M414 Medical Center, University of Florida, Gainesville 32610.

Scientific Exhibit Applications Invited

The Committee on Continuing Medical Education is still accepting applications for scientific exhibit space at the 102nd Annual Meeting of the Florida Medical Association at the Diplomat Hotel in Hollywood in May, 1976.

Deadline for receipt of applications is January 1, 1976, according to E. Eddy Burns, M.D., Exhibit Chairman. Application forms may be obtained by writing to Dr. Burns, Florida Medical Association, P.O. Box 2411, Jacksonville 32203.

Installation of exhibits may begin at noon, Wednesday, May 5. They are to be ready for showing at 8:30 the following morning. Dismantling may not begin before 3:00 p.m. on Saturday, May 8.

The Florida Regional Medical Program
A Report

Gordon R. Engebretson, Ph.D., Granville W. Larimore, M.D. and
Coyle E. Moore, Ph.D.

In December, 1964, a Presidential Commission on Heart Disease, Cancer and Stroke reported serious inadequacies in the handling of these diseases and recommended the enactment of legislation to establish a network of "centers of excellence" distributed around the country to which physicians could refer patients.

Congress rather forcefully rejected this proposal and instead enacted the "Heart Disease, Cancer and Stroke Amendments of 1965" which became Public Law 89-239 upon the signature of President Johnson in October of that year. The law's goal[1] was stated to be, "to advance the accessibility and the quality of health care available throughout (each) region for heart disease, cancer, stroke and related diseases."

Congressional rejection of the Commission's proposal, sound though it is believed to be, represented but the first in a series of legislative and administrative zig-zags which have plagued the orderly development and implementation of the Regional Medical Programs (RMPs). In 1968, Congress in Public Law 90-574 continued the Program for only a two-year period, which made long-range planning difficult.

In 1970, the 91st Congress extended the Program, this time for three years and made some very significant alterations in its content. Added were emphasis on: primary care, the regionalization of health care resources, prevention and rehabilitation and the disease categories were expanded to include kidney disease. Emphasis was also placed on health service delivery and manpower utilization.

In June, 1971, the Administration issued an RMP Mission Statement which represented yet another shift in direction for the Program. The statement set forth four major objectives. These stressed (1) new techniques and innovative delivery patterns for improving accessibility, efficiency and effectiveness of health care, (2) activities which would help existing manpower provide more and better care and stimulate the more effective utilization of new kinds of health manpower, (3) encouragement to providers to participate in the regionalization of health care services and facilities, (4) assistance in developing and facilitating the implementation of new and specific mechanisms to provide improved standards of health care.

It has been assumed by some that the Mission Statement represented an attempt by the national Administration to use the RMP mechanism as an instrument to mold the nation's pluralistic health services system into the Administration's own conceived image of what that system should be. Viewed in the perspective of more recent developments, one can readily detect the seeds of HMOs, PSROs and similar mechanisms in the 1971 Mission Statement.

The 1971 statement received something less than a favorable response from physicians and other health professionals as well as the staffs of the RMPs and the individual citizens serving on RMP policy-making bodies. Predictably, perhaps, the Administration's reaction was to recommend on January 29, 1973, that RMPs be closed down by June 20, 1973, and no funds for the 1973-74 fiscal year were included in the President's budget. Astonishingly, a major justification for the Administration's action was its statement that there was no consistent theme in RMP programs. This criticism was leveled in spite of six consecutive years of repeated shifts in legislative and administrative directions for the Program.

Congress responded rather quickly to the Administration's January 29th statement by Senate action on March 25th and a House vote on May 31, 1973, to continue RMP. The Senate and House votes were both overwhelmingly favorable (94-0 and 372-1). Phaseout orders were rescinded but operating funds were impounded by the President. The National Association of RMPs

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brought suit in Federal Court, the impoundment was judged illegal and $115 million were released.

Some RMPs (Florida's was not among them) suffered irreparable damage as the result of the Administration ordered phaseout. Staffs were lost, and confidence was destroyed among the professional associations and health agencies as well as the many citizen volunteers with whom the RMPs had been working. So even though Administration efforts were nullified by subsequent congressional and court actions, much harm had been done. In Florida, the Program's staff was cut back but key personnel stayed on and many projects were continued although at a reduced level until court released funds became available.

As a result of the court action releasing funds and the rescinding of the phaseout orders, RMPs, at least those who were able to maintain their staffs during the 1973 turmoil have had very productive years in 1974 and 1975.

In spite of the many continuing problems presented by the perennially shifting legislative and administrative bases for the RMPs, the Florida Regional Medical Program (FRMP) through its Advisory Group, Board, Task Forces and staff strived to make the Program maximally effective in meeting Florida's health service needs.

The FRMP's objective has been: "To raise the levels of health care in Florida by assisting physicians, allied health personnel and their medical institutions in providing the highest quality health services in their own communities, and to increase accessibility and availability of these services with special attention to heart disease, cancer, stroke, kidney disease and related diseases."

As was pointed out earlier in the JFMA[2] the regional medical program concept is almost tailor-made for Florida. The State's law against the dissection of the human body barred medical schools until the 1950's and left the state far behind its southeastern neighbors not only in medical research and education but in tertiary level care resources as well. FRMP with its emphasis on continuing education for health care providers, improving accessibility and the development of critically needed specialized resources, has played a key role in helping Florida "catch-up" in such areas as end-stage renal disease, coronary care, neonatal care and emergency medical services.

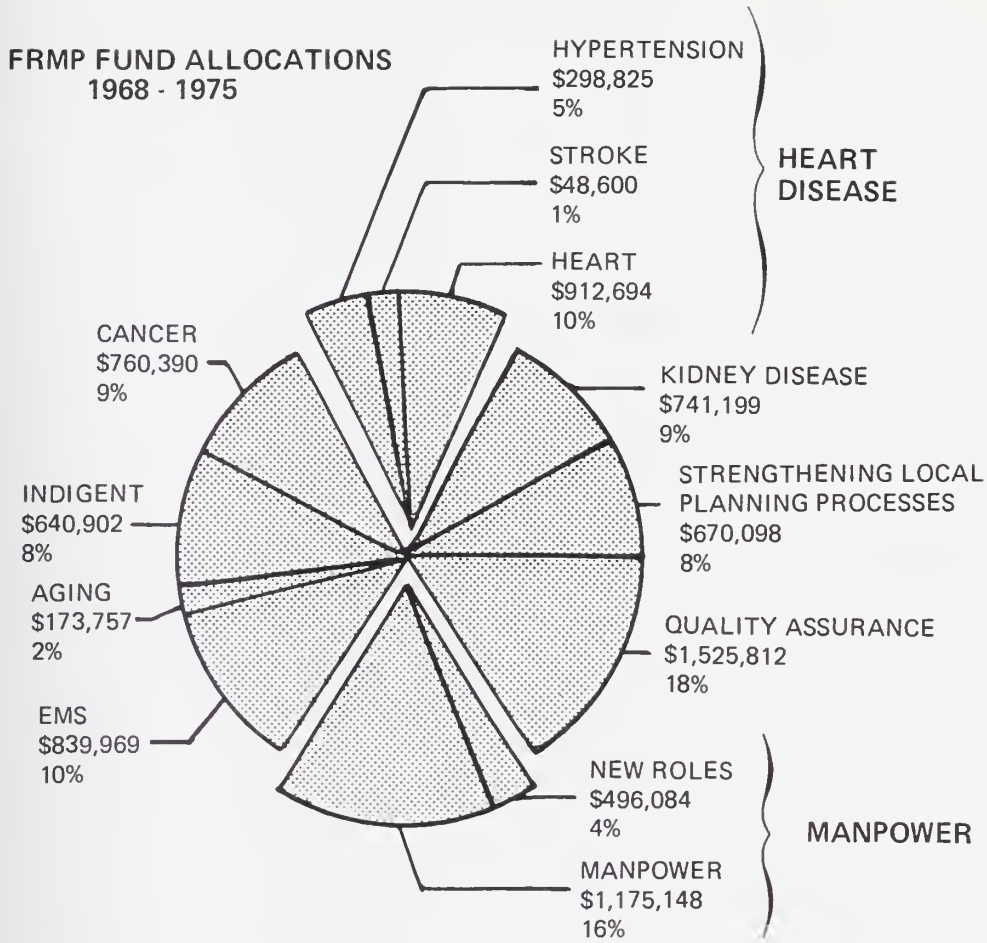
FRMP's achievements have been facilitated by several principles which have guided the Program from the beginning. These include, within the constraints of the law, making here in Florida and not in Washington, the decisions regarding the activities to be undertaken within the state; the promotion of cooperative participation among medical, other health care provider groups, educational and institutional representatives in the decision-making process. While many distinguished Floridians have participated in FRMP as consumer advisers, some 400 of the approximately 500 Floridians who have worked as volunteers in the Program, since its inception, have been physicians.

The one goal that has constantly been first among FRMP volunteers and the staff has been to use FRMP's resources for maximum effectiveness in endeavoring to make Florida a healthier and better place in which to live.

A few examples of the 146 FRMP projects since 1968 will perhaps suffice to illustrate the breadth and character of FRMP efforts during its seven-year life.

1. *Coronary Care:* As has been previously described[3] there were in 1969 many rural areas in the State without specialized units for coronary care (CCUs). In fact there were vast areas from Jacksonville across to Tallahassee and approaching Pensacola which lacked such facilities. A major factor was the lack of trained CCU nurses. FRMP in cooperation with the Florida Heart Association developed a series of four-week training courses for CCU nurses. The Program was offered in four teaching medical centers in the State. Some 500 nurses were trained in three years to meet the critical staff needs for CCUs throughout the State. At the conclusion of the initial program, CCU training was integrated into Florida's nursing school curricula to provide a continuing supply of trained CCU staff. Of great importance too was the "Course of Instruction in Coronary Care for the Practicing Physician" initiated with FRMP support and now in its sixth year of operation.

2. *Emergency Medical Services:* In FRMP's 1971 review of major health service problems in Florida, Emergency Medical Services (EMS) received a top priority. Florida lacked a comprehensive system for providing EMS; it also lacked adequate laws for the effective regulation of EMS on a statewide basis. For example, Florida Statute required only 8½ hours training for ambulance attendants.[4] In 1970, over 2,100 people died in Florida from automobile accidents and 25,000 of the 40,000 deaths from heart disease occurred within the first hour after onset of symptoms. Many of these lives and others as well could have been saved through an effective EMS system.



As a first step, FRMP in consultation with the Florida Medical Association, Florida Division of Health, Florida Hospital Association, the medical schools and other interested groups, developed a statewide EMS plan. The plan was completed in early 1972 and implemented with FRMP funds as a cooperative enterprise with the Division of Health. For this pioneer effort there was full support from the Governor and the Legislature. Combined with the effect of subsequent Federal funding legislation and State appropriations this FRMP project helped to provide Florida with one of the finest EMS systems in the nation.

3. *Neonatal Care:* Candidly, Florida's past record in neonatal care can scarcely be viewed with pride. In 1970, Florida ranked 39th among the states in infant mortality. In that year, 2,470 babies died in the first year of life, 1,848 of them in the first 28 days after birth, the critical neonatal period. Florida lacked a comprehensive neonatal intensive care system that could react quickly and effectively to meet the needs of the critically-ill newborn. In 1971, FRMP, after an analysis of the neonatal care problem, developed with the cooperation of the Florida Academy of Pediatrics, the Florida Division of Health, the State's medical schools and later the Division of Children's Medical Services, a neonatal intensive care program[5] which has four major components: identification of neonatal nurseries according to three levels of capabilities; a communications system; a transportation system (including MAST which FRMP also helps fund) and an educational program.

The number of neonatal deaths in Florida has dropped from 1,848 in 1970 to 1,389 in 1974.

4. *End-Stage Renal Disease:* In 1970, with the expansion of the RMP Act to include renal disease, FRMP moved quickly to bring its resources to bear on the problem in Florida.[6] A review of the status at that time indicated that there were inadequacies in dialysis facilities, particularly in the central and northern parts of Florida, and a critical lack of transplant capabilities. Only 25 kidney transplants were done in the State in

1971. In cooperation with the medical schools and with the State's major resource in this area—its growing number of nephrologists—FRMP devised a statewide plan aimed primarily at plugging the gaps in dialysis and transplantation. Dialysis facilities were established in Pensacola and Orlando and those in Jacksonville were augmented. Improved tissue-typing capability, an essential for successful transplantation, was established. Efforts were also made in organ procurement and in the educational area. Some $741,000 of FRMP funds have been utilized in the kidney program which now receives support from the State and other federal sources. The results have more than justified the expense. Florida's dialysis needs are now being generally met and the transplant activity will exceed 150 this year—a six-fold increase from the 25 of 1971.

5. *Groups with Special Health Problems:* FRMP's advisers and its staff recognized in Florida a number of population groups who present special problems from the standpoint of health. Numbered among these are the inner-city poor, the migrant farm workers and the Indian tribes (Seminoles and Miccosukees) in the Everglades. The specific problems are different for each of these groups. For the inner-city poor, health services are often available but generally utilized only on a "crisis" basis because of cultural barriers, inadequate education and a lack of understanding or appreciation for the preventive concept. For this group, FRMP developed demonstrations utilizing a category of indigenous nonprofessional health workers known as "Health Guides" whose job was literally one of guiding the inner-city poor in the effective use of existing health care resources. Migrants possess some of the same problems of the inner-city poor, plus non-availability or accessibility of health services. For this group, FRMP has operated a number of projects which have had educational objectives as well as providing assistance in improving the availability of health care services. The Indians faced yet another problem—that of inadequate emergency medical services—a result of the tribes' isolation, wide distribution over large areas and long distances from hospitals. For them FRMP has offered training in emergency care and provided transportation and communication equipment.

6. *Continuing Education:* Continuing education has had a prominent place in all of FRMP's efforts from its very beginning. Educational activities have been extensive and varied.[7] There have been intensive short-course programs on specific topics such as heart disease, cancer and stroke at the medical schools in which hundreds of Florida physicians participated. Since 1968, FRMP has supported literally hundreds of consultants who have brought continuing medical education to medical societies, hospital staffs and specialty groups. A recent activity has been a cooperative effort with the Florida Medical Foundation to provide seminars for physicians in the techniques of medical peer review.

7. *Children's Cancer Consultation:* In 1970, FRMP's Cancer Task Force pointed out that the rapid advances[8-18] that had been made in the treatment of cancer in children—in both the leukemias and solid tumors—could be expected to produce significant, even dramatic improvements in the child's condition and potential longevity. FRMP's advisers recommended the provision of FRMP "seed money" to fund several service centers in Florida to which physicians could refer children, whom they suspected of having cancer, for confirmation of diagnosis and the development of a treatment schedule to be administered by the child's own physician. The FRMP Advisory Group and Board accepted the proposal and consultation centers were set up in Tampa, Miami, Jacksonville and Gainesville. These were operated for three years with FRMP funds.

8. *Control of Hospital-Acquired Infections:* The scope of FRMP's concern with Florida's health problems can also be seen by its support of two demonstration programs, one in the Miami area, the other in Tampa, aimed at the detection and control of hospital-acquired infections. The seriousness of the problem is reflected in the more than 50,000 Americans who die each year from hospital-acquired infections—roughly the same number that die from automobile accidents.[19] Moreover, the cost of such infections exceeds $500 million annually. The goals of the FRMP hospital-acquired infection control projects are: (1) education of physicians and hospital personnel in the recognition of infections and the identification of patients at greatest risk and (2) elevation of the standards of hospital care so that infections are decreased or eliminated. Extensive use has been made of specially trained nurse epidemiologists whose efforts in cooperation with attending physicians and hospital personnel have resulted in dramatic improvements in the hospital-acquired infection picture.

9. *Early Detection of Disease:* There is ample evidence that the preventive effort exemplified by early detection and prompt treatment of disease is both medically and economically sound. FRMP and its advisers early recognized the value of screening for disease and the prompt referral to their physicians of those among whom the screening procedures detected possible abnormalities. FRMP has supported twelve detection projects including cervical cytology screening by means of the Pap test;[20] cardiovascular screening through EKG, blood-pressure, chest x-ray and a battery of blood chemistry evaluations[21] and a community based multi-phasic screening project utilizing sophisticated on-line computerization and analysis of data.

The above examples are cited as illustrations of the breadth and depth of FRMP's concern with Florida's priority health problems. Other problem areas for which space does not permit even a summary description include: consultation in genetically determined disease problems, care of the severely burned, school health education, cardiovascular risk factor reversal, training in the microsurgery of stroke, a drug information and pharmacy resource center, rehabilitation, respiratory disease consultation, rheumatic fever control, patient education in a family practice setting, health manpower (some dozen projects), dental service models, perinatal care, MAST (Military Assistance for Safety and Traffic), health care delivery in short-term penal institutions and others for a total of 146 Florida projects, plus several one-time studies over a period of seven years.

From the beginning, it has been a cardinal principle of FRMP's operation to keep its staff small, but highly skilled, and to keep its operating overhead at the lowest possible level. The overriding objective has been to secure maximum benefit for the people of Florida from every dollar awarded to the program. FRMP has also endeavored to cooperate fully with physicians and other health professional groups and institutions and to avoid duplication and overlap with existing facilities and services.

In this cooperative effort, FRMP has brought to Florida over $8.2 million in federal funds since 1968 to support worthwhile project activities. Figure 1 represents the manner in which these funds were applied to support various types of projects.

What of the future? The latest turning point in the winding path that has been the Regional Medical Programs' course came with the passage of Public Law 93-641, "The National Health Planning and Resources Development Act of 1974" during the closing days of 1974 and its signature by the President on January 4, 1975. The Act combines Comprehensive Health Planning 314 "b" agencies with RMPs into a series of new agencies to be known as "Health System Agencies" of which Florida will have nine.

Title XVI of the Act, entitled "Health Resources Development", provides for the continuation of the RMP function. However, funds will not be made available to implement Title XVI until at least fiscal 1977 and then on a limited basis so it is likely that many of the valuable and important projects now being carried by RMPs will simply go down the drain between the ending of RMP funding and the start of adequate funding under Title XVI.

This involved account of the RMP's tortuous, short-lived existence is presented not only as an account of one Program, but as a not so atypical case history of inconsistent federal actions in the health field. If such history is but prologue there is certainly room for concern and scepticism about the ever increasing federal involvement in the health area.

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The Florida Regional Medical Program

A Comment

H. Phillip Hampton, M.D.

Regional Medical Programs provided a vehicle for the medical profession, other private health care providers, and government to cooperatively seek solutions for problems in health care delivery in order to improve the efficiency, quality and availability of health care.

This report cites some of the achievements of the Florida Regional Medical Program from those cooperative efforts. There were also administrative difficulties and frustrations in initiating or completing badly needed programs.

Regional Medical Programs were at their best in the low key role of support to health care providers, medical education and evaluation programs. It was the policy of the Florida Regional Medical Program to fund those programs within their objectives that had probability of subsequent financial support from their own efforts or other sources and could thus be continued by an appropriate organization in the private sector. The Peer Medical Utilization Review program with the Florida Medical Foundation is a current example which has great promise if coordinated with medical education.

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It is unfortunate that some physicians were disinclined to cooperate in regional medical programs apparently because of an innate suspicion of government and the use of tax funds in this activity. The recently increased emphasis by the Administration on consumer dominated planning agencies designed to achieve a reduction in expenditures for health care will apparently destroy RMP, the only available vehicle for the cooperative approach to health care problems.

An adversary relationship is being established through regulations published in the Federal Register and a new militancy of opposition by the private medical sector. Will this protagonism be more productive and less costly? Will the lack of a vehicle for government and the private sector to cooperatively approach health care solutions prevent the preservation and development of systems of health care in which the patient and physician have a freedom of choice? Answers to these questions will not be avoided by silence or apathy.

A BILL THAT WOULD ESTABLISH PHYSICIAN FEE SCHEDULES under Medicare and Medicaid was opposed by the AMA in a letter to the House Ways and Means Committee's Subcommittee on Health. Under the bill, HR 6699, physicians participating in the fee schedule program — to be set up by state governors — would be required to accept the scheduled amount as full payment, and their payments would not be subject to the usual deductible and coinsurance. Physicians who do not participate would be paid on the basis of present reimbursement programs, subject to deductible and copayment. The AMA said such a bill would "create an unprecedented system of price controls which is arbitrary and discriminatory. It provides for an arbitrary schedule of fees controlled by an artificial ceiling selected only on the criteria of predetermined levels of expenditures. The bill is grossly unfair and would cause immediate rollbacks in reimbursement for most physicians."

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Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Lomotil is contraindicated in children less than 2 years old.

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Each tablet and each 5 ml of liquid contain diphenoxylate hydrochloride 2.5 mg. (Warning: May be habit forming), atropine sulfate 0.025 mg.

holds the line.

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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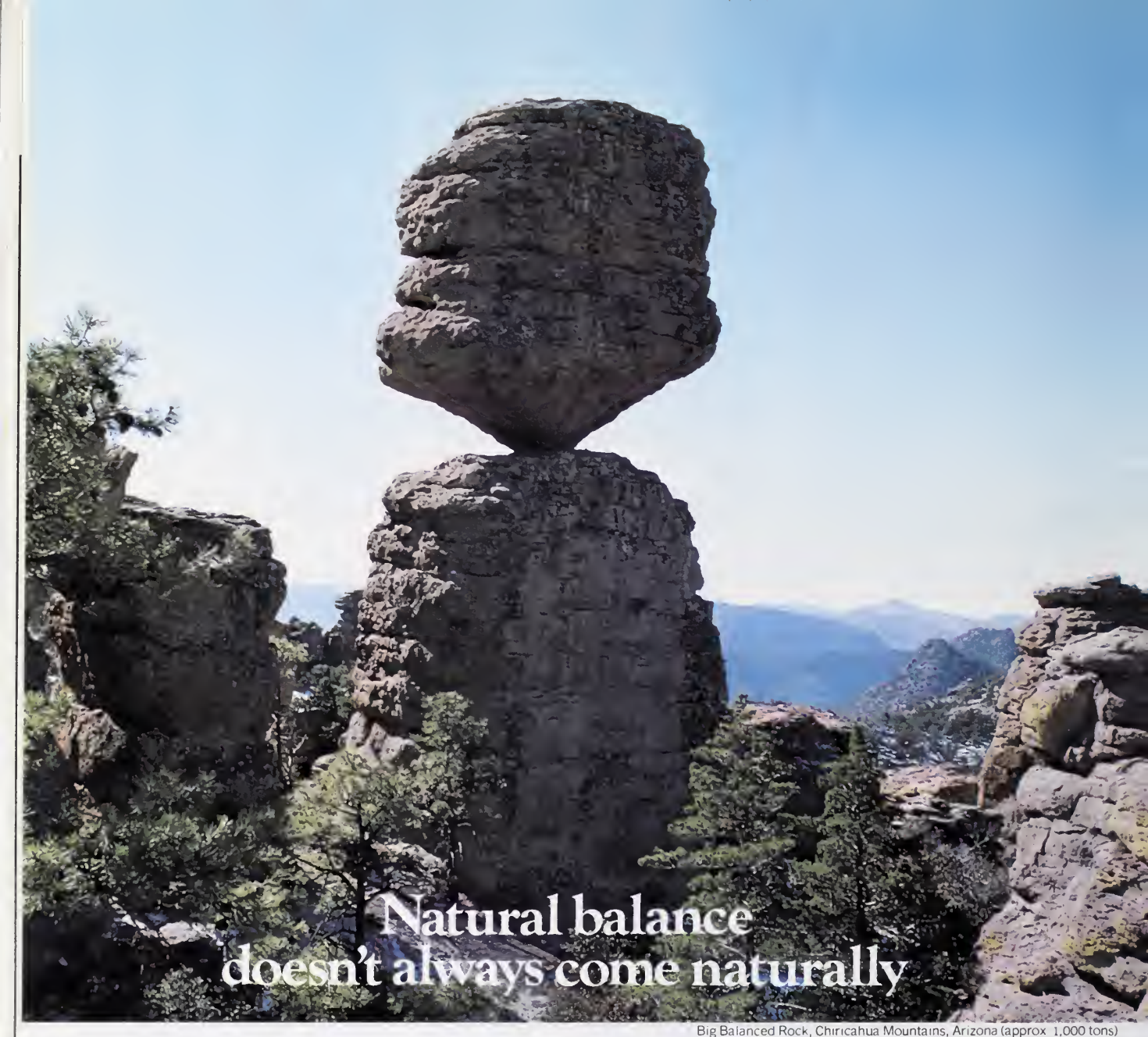

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Editorials

This, Too, Shall Pass

As Christmas 1975 approaches, the Near East, and with it the political world, seems nearer to peace than in more than 2000 years because of the Israel-Egypt treaty. Yet, the medical world appears farther from peace than ever despite greater scientific advancement in the few months less than half a century since I entered the Johns Hopkins University School of Medicine than in all previous history. PSRO, UR and the rest of the federal government alphabet-gobbledygook are denounced as presaging bureaucratic control of every act in the physician's professional life. Bills for compulsory health insurance, introduced into every Congress since the days of Roosevelt II, are seen as threatening to make doctors mere minions of the federal government. A tide of foreign medical graduates promises, in the eyes of many, to inundate the practice of medicine. And, worst of all, the malpractice question appears to generate new problems faster than the old ones can be solved even by temporary means.

Does all this presage the end of private medical practice in the United States as it has been known since colonial days? Hardly, for Americans have a peculiar genius for solving their own problems.

In 1831, almost a century and a half ago, Alexis de Tocqueville, French statesman and writer, visited America and wrote: "These Americans are the most peculiar people in the world. In a local community in their country, a citizen may conceive of some need that is not being met. What does he do? He goes across the street and discusses it with his neighbor. Then what happens? A committee comes into existence and then the committee begins to function on behalf of that need, and you won't believe this but it's true. All this is done without reference to a bureaucrat. All this is done by the private citizens on their own initiative."

The problems of Medicine '75 may not be solved quite so simply as in de Tocqueville's day, but they are being and will be solved. Government controlled medicine has proved to be a dismal failure in England after roughly 50 years of trial. Even the malpractice question was a lot worse 4000 years ago in the time of Hammurabi when: "If the doctor shall open an abscess with a bronze knife and shall kill the patient. . . .his hands shall be cut off." And as for PSRO, UR and the rest, the AMA recently went into the courts and forced the Department of Health, Education and Welfare to back down in its demands for possibly lay-dominated boards to review Medicare and Medicaid admissions. All of which would appear to herald a new era of mutual respect and cooperation between organized medicine and the federal government leading to some form of universal medical care that both can live with and still retain a certain amount of freedom to act independently.

Of course, there will be more problems by Christmas '76 but with coolness and a certain amount of benign neglect, they, too, shall pass.

Merry Christmas!

FRANK G. SLAUGHTER, M.D.
JACKSONVILLE

Dr. Slaughter is a Life Member of the Duval County Medical Society, Florida Medical Association, American Medical Association, American College of Surgeons, and one of the first Diplomates of the American Board of Surgery by examination in Florida. He is the author of 56 books, and more than half of these deal with the medical scene, modern and historical. Since his first novel, "That None Should Die," appeared in 1941 more than 60 million copies of his writing have been published in all editions throughout the world.

To "Care For" is an Act of Love

This month of December is one of great religious significance. It contains major holy celebrations of the Judeo-Christian community. The majority of the membership of the Florida Medical Association identifies with one or the other of these religious groups.

There is great emphasis in the scriptures of these related religions on the commitment of love. God's love for us, our love for God, and the need for each of us to love our fellow man . . . who like each of us is a child of God. There are many times that each of us is unlovable, but we are always loved by God and fortunately those close to us do not turn from us at such times.

In the training of the physician there are two glaring voids. That which trains us in the area of human love and compassion, and that other void being an utter lack of business training. We finish school and set about a practice which we call "caring for our patients."

Love is a very important and basic factor in the care of a human being. It is something he is entitled to even when—as each of us has often been—he or she seems unlovable. It is a basic human need. It is a therapeutic element which gives a feeling of wholeness and dignity to each of us and our patients.

The physician or health worker who fails to communicate this warmth of human kindness and love to his or her patient is less than a complete professional and short changes those in their care.

Edward L. Cole, M.D.
St. Petersburg

Case Report

Gynecomastia Following Digitalis Administration

by Charles J. Wolfe, LL.D., M.D. (Editorial revision by Clifford R. Guy, M.D., Jacksonville)

Introduction

While the relatively high incidence of digitalis-induced dysrhythmias is well established, the extracardiac effects of the digitalis glycosides are less widely appreciated. The most commonly cited of these include gastrointestinal and visual symptoms, but adverse effects have included neurologic,[1] endocrinologic,[2-6] allergic[7] and even hematologic[8] responses. Importantly, these systemic effects are inconstant and unreliable concomitants of digitoxic dysrhythmias. The following case report illustrates the appearance of reversible gynecomastia related to digoxin therapy and reviews the previously postulated mechanism of this action.

Case Report

On August 27, 1973, a 77 year old white male with no prior history of cardiopulmonary symptoms presented with a complaint of nausea, mild dyspnea, and chest "heaviness" of several days' duration. He was found to be in atrial fibrillation with a ventricular response of 110 per minute. Blood pressure was 110 to 140 systolic, 60 to 80 diastolic, and no evidence of valvular disease or myocardial enlargement was present on examination or electrocardiogram.

He was given digoxin orally, for a total of 1.5 mg. over an 18 hour period, followed by a maintenance dose of 0.25 mg. daily. He converted to normal sinus rhythm within 2 days at a rate of 72 per minute. Periodic followup visits in January and February 1974 revealed persistence of a normal sinus rhythm at 62 to 70 per minute. No drugs other than digoxin were taken during this period or subsequently.

In May 1974, bilateral breast swelling and tenderness were noted by the patient, but were not reported by him until August 22, 1974. Both breasts were exquisitely painful to palpation, revealing a firm, rounded subareolar enlargement bilaterally of 6 cm. in diameter. No evidence of systemic feminization or hepatic dysfunction was present; neither digoxin nor hormonal assays were obtained. Digoxin was discontinued.

When seen in February 1975, both breasts had returned to normal, and the patient had remained in sinus rhythm. Late followup on September 16, 1975, revealed him to be free of complaints or breast abnormalities, and in normal sinus rhythm at 58 per minute on no medications.

Discussion

Digitalis-induced gynecomastia has been noted in scattered reports throughout the literature.[2-6,9-12] The mechanism of action has been related to estrogenic effects of the cyclopentanophenanthrene nucleus common to estrogens, progesterone, and the digitalis aglycones.[2,6] An estrogenic effect on the vaginal mucosa of postmenopausal women on long-term digitalis therapy has been seen[4]; this estrogenic effect in an elderly male presumably encouraged the development of gynecomastia in the patient described. Although no assay of digoxin or hormone levels was obtained in this case, the appearance and remission of breast changes correlated completely with the period of digoxin administration. Significantly, the patient was free of evidence of cardiac toxicity or hepatic malfunction; the latter had been tentatively implicated in earlier reports[2] of this phenomenon, but has not been subsequently substantiated as a necessary factor. Although benign in its nature, digitalis-induced gynecomastia may be quite worrisome to the patient involved. This case reemphasizes the need for familiarity with the potential systemic effects of drugs usually employed for action on a specific organ or subsystem.

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ORGANIZATION

Excerpts from Summary Report Meeting of the Board of Governors October 9-11, 1975

The following are excerpts from the summary of actions taken by the Board of Governors at its recent meeting. The following items were approved for consideration by the House of Delegates in January:

—$100 assessment for FMA active members to be used for legislative and public relations activities
—Telephone Directory Yellow Page Listings
—Continuing Medical Education—AMA Physicians' Recognition Award
—FMA Legislative Program

GOVERNMENT PROGRAMS	Allotted time during the FMA Annual Meeting for a program to be presented on items of pertinent medical interest to physicians to include PSRO legislation, DHRS reorganization, comprehensive health care planning, etc.
FMA JOURNAL LEGISLATIVE MATTERS	Allocated space in each issue of *The FMA Journal* for reporting on state legislative matters.
COST CONTAINMENT	Expressed the opinion that it is not the obligation of physicians to provide cost containment and medical care information to the U.S. Government and advised the Florida Physician's Association of this action and requested their assistance in disseminating this information to physicians in the state.
WORKMEN'S COMPENSATION	Instructed FMA legal counsel to appeal the order entered September, 1975 by the Division of Labor denying the FMA's petition for modification of the medical and surgical fee schedule for workmen's compensation.
FMIT DENTAL COVERAGE	Approved pursual of the feasibility of including dental benefits under the major medical portion of the FMIT Program provided that this additional coverage is made optional.
NATIONAL HEALTH INSURANCE	Discussed testimony to be presented by the FMA President, Dr. Vernon B. Astler, in his appearance before the U.S. House Ways and Means Committee November 12, 1975 regarding national health insurance and Florida's position.
YELLOW PAGE LISTINGS	Recommended to the House of Delegates at its Interim Meeting in January adoption of the policy that only those specialties and subspecialties which have certifying boards and which are recognized by the AMA be used for telephone directory listings in the yellow pages.
SPECIAL COMMITTEES	Authorized appointment of special Committees on Nursing Homes and Sports Injuries to report to the Board in these two areas of concern.
OSTEOPATHIC MEMBERSHIP	Requested the Judicial Council to draw up guidelines for evaluation of osteopathic physicians for membership in county medical societies for presentation to the House of Delegates at its 1976 Annual Meeting.

(The Board of Governors was instructed by the 1975 House of Delegates to prepare a By-laws amendment regarding admission of Doctors of Osteopathy who have completed an AMA approved Internship or Residency to county medical societies and the FMA for consideration at the 1976 Annual Meeting of the House of Delegates.)

PRESS, RADIO AND TV RELATIONS

Received a report from Dr. Robert Windom, Chairman of the FMA special Committee on Press, Radio and TV Relations outlining activities to improve relations with the media, use of the media for the benefit of physicians and establishment of day-to-day liaison with the press and TV.

COMMITTEE ON PLI LEGISLATION

Approved a preliminary report of the Committee on PLI Legislation outlining general areas of legislative consideration to improve the professional liability insurance atmosphere, and directed that this committee refine its recommendations for legislative priorities and report to the Board prior to the House of Delegates meeting in January. This Committee was also requested to address themselves to long-range plans for solving the PLI problem.

GRIEVANCE PROCEDURES

Encouraged the Judicial Council in its efforts in working with county medical societies' grievance committees to improve grievance procedures in a manner consistent with good patient public relations.

FAMILY PRACTICE RESIDENCIES

Expressed support for increased funding for family practice residencies and primary care physician residencies and encouraged increased funding for community hospital education programs.

ADVERTISING PRICES ON PRESCRIPTION DRUGS

Opposed legislation which would remove restrictions on advertising prices of prescription drugs.

REIMBURSEMENT OF DERMATOLOGISTS FOR PATHOLOGY REPORTS

Disapproved a recommendation that Board qualified or certified dermatologists be reimbursed by third party carriers for performing their own pathology.

DISABILITY DETERMINATION

Requested the Bureau of Disability Determination, Division of Vocational Rehabilitation, to furnish each applicant for disability determination with a carbon copy of the letter requesting a medical report with the following sentence underlined: "The applicant is responsible for any costs involved in furnishing this information."

RVS GUIDELINES FOR CO-SURGEONS AND ASSISTANT SURGEONS

Urged all county medical societies' insurance review committees to utilize the guidelines in the Relative Value Studies as they pertain to payment for co-surgeons and assistant surgeons.

RELATIVE VALUE STUDIES

Approved a recommendation from the Council on Specialty Medicine that final approval of the 1975 RVS be deferred until the January meeting of the Board of Governors in order to allow a reasonable amount of time for review and recommendations by the specialty groups.

PHYSICIAN RECRUITMENT CONFERENCE

Approved FMA sponsorship of a Physician's Recruitment Conference to inform communities on the problems associated with setting up medical practice in underserved areas and suggest ways that communities might attract physicians. The Conference is to be coordinated by the Council on Medical Services.

TASK FORCE ON RURAL HEALTH

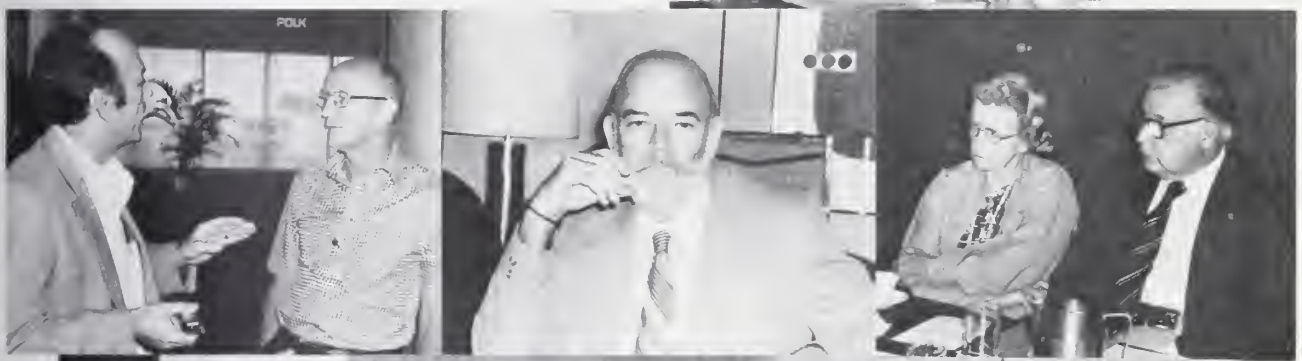
Encouraged the formation of a statewide task force consisting of members of the FMA, State Legislature, and other concerned individuals, to evaluate the need for medical services in under-served areas and recommend possible solutions for providing health care delivery in under-served areas.

PRIMARY CARE PHYSICIANS

Commended the Board of Regents for their current and continued emphasis on primary care physicians.

UNIFORM ACCOUNTING SYSTEM AND REGULATION COMMISSION	Adopted the position of favoring a hospital and nursing home uniform accounting system with public financial disclosure and requested the State of Florida to adopt a single reporting form to be used by all state agencies requiring reports from hospitals or physicians.
CENTRAL REGISTRY OF DISABLED PERSONS	Directed that the FMA membership be notified in the next issue of the "Briefs" as to the provisions of Senate Bill 588, a 1974 law establishing a central registry of severely disabled persons and the potential legal recourse a patient may have against physicians who are not complying with this law, and recommended amendments to the current law which would make it more palatable.
FOUNDATIONS FOR MEDICAL CARE	Approved recognition of the Foundation for Medical Care for the Big Bend Area of Florida, Inc. which includes representation on the FMA Committee on Foundations for Medical Care.
COMPREHENSIVE HEALTH PLANNING	Emphasized the importance of the FMA and its component county medical societies becoming actively involved in the appointment of members to local and state health planning agencies to ensure physician input and guidance.
TIME RESPONSE TO STATE AND FEDERAL RULES AND REGULATIONS	Adopted a resolution requesting state and national legislators to increase the time limit for response to proposed rules and regulations to 90 days.
CONTINUING MEDICAL EDUCATION	Approved appointment of a Committee of the Florida Medical Foundation for the purpose of conducting, sponsoring or co-sponsoring Category 1 CME courses.
PHYSICIAN'S ASSISTANTS	Approved admission of physician's assistants to FMA scientific programs in the company of or at the request of the employer physician provided they are properly identified and that they pay the registration fee for nonmembers.
FIFTH PATHWAY	Reaffirmed the position that implementation of the so-called Fifth Pathway at this time would not be in the best interest of the people of Florida.
SPECIAL PROGRAMS FOR MEDICAL STUDENTS	Received a report from the Committee on Medical Education regarding the development of a series of special programs for students in Florida's three medical schools to include instruction on medical ethics, the role of organized medicine in the community, professional liability, the physician-patient relationship, continuing medical education, and the functions of the FMA and the State Board of Medical Examiners.
FLORIDA SOCIETY OF NEONATAL-PERINATOLOGISTS	Granted FMA recognition to the Florida Society of Neonatal-Perinatologists which brings to 35 the total number of specialty groups currently recognized by the FMA and which have representation on the Council on Specialty Medicine.
MEDICARE PART B	Directed that the FMA take whatever means available to seek reversal of the ruling of the Society Security Administration regarding Medicare Part B which places limitation on the maximum prevailing level of payment to physicians and beneficiaries.
NURSE PRACTITIONER	Recommended to the State Board of Medical Examiners that when and if a Nurse Practitioner or Nurse Assistant performs any act not covered by the Nurse Practice Act that these acts only be under the responsible supervision of a qualified physician and that they not be allowed to bill for third party payments.
NO-FAULT INSURANCE	Reviewed a report from Dr. Richard C. Dever, FMA representative on a special task force appointed by the Insurance Commissioner to look into alleged abuses by physicians and attorneys of Florida's no-fault automobile insurance program. It is expected that the report of the task force will be submitted sometime after the first of the year.

MEDICARE	Directed that FMA contact Florida's U.S. Senators and Representatives to voice strong objection to the regulations implemented by the Bureau of Health Insurance on August 11, 1975 through its administrator Blue Shield of Florida and the Group Health Insurance Company, a fee schedule of reimbursement for laboratory services that is discriminatory to the Medicare recipient in the state and that has not been implemented in any other region in the U.S.
HRS MEDICAL SERVICES COORDINATOR	Noted with great pleasure the appointment of Charlotte MaGuire Behrman, M.D. as Medical Services Coordinator to the Department of HRS and expressed full cooperation and support by the FMA, and to assist in the work of a special task force headed by Dr. Behrman which is evaluating Florida's Medicaid Program.
FLAMPAC BOARD OF DIRECTORS	Approved appointment of H. Quillian Jones Jr., M.D., Ft. Myers, as FLAMPAC Board member from the 10th Congressional District and Fred Butler, M.D., Naples, as his alternate.
WOMAN'S AUXILIARY	Expressed appreciation to Mrs. Ruth Henderson, President of the Woman's Auxiliary to the FMA, for the many fine efforts of the Auxiliary on behalf of the Association and endorsed projects of the Auxiliary during the coming months to include National High Blood Pressure Month, Immunization Month, Safety on the Streets, Rural Health Week, Doctor's Day, and Quality of Life Conference.
FMF STUDENT LOAN PROGRAM	Declared an indefinite moratorium on the granting of loans to medical students through the FMF Student Loan Program due to bad loss experiences under the program.
FMA CAPITAL OFFICE	Approved purchase of a building in Tallahassee located on the northeast corner of College Avenue and Adams Street approximately one block from the Capital to house FMA Capital Staff. The building should be renovated and ready for occupancy by early January, 1976.
FMA STAFF	Received a report from the Executive Vice President regarding additions to the FMA staff which include the hiring of Mr. Charles Murfin to serve as Executive Director of FLAMPAC and a full-time legislative analyst for the FMA Capital Office. The FMA will also have the services of an in-house legal counsel who is being hired for PIMCO.
FMA-PLI-TRUST	Requested Dr. James W. Walker to consider the position of President of PIMCO, and nominated Dr. Walker to the Board of Directors of PIMCO for consideration as its President. Approved the appointment of O. William Davenport, M.D., Miami, by the FMA-PLI-Trustees as the fifth Trustee. Other Trustees include Vernon B. Astler, M.D., Jack A. MaCris, M.D., Richard S. Hodes, M.D., and James W. Walker, M.D.
AMA COUNCILS AND COMMITTEES	Approved nomination of the following physicians for appointments or reappointments to AMA Councils and Committees: —Council on Food and Nutrition: Yank Coble, M.D., Jacksonville —Council on Health Manpower: James W. Walker, M.D., Jacksonville —Council on Legislation: Louis C. Murray, M.D., Orlando —Committee on Community Emergency Services: Ray M. Baker, M.D., Jacksonville —Committee on Insurance: Samuel Day, M.D., Jacksonville
AMA VICE PRESIDENT	Enthusiastically endorsed the candidacy of Francis T. Holland, M.D., Tallahassee, for election to the office for Vice President of the AMA.
AMA BOARD OF TRUSTEES	Noted with pleasure the overwhelming reelection of Jere Annis, M.D. as a member of the AMA Board of Trustees and also his election as Vice Chairman of the Board, and Chairman of the Finance Committee.



Four county medical society editors met with FMA's Committee on Scientific Publications in Tampa on October 25 to trade ideas as to how their publications and the *Journal of the Florida Medical Association* might become more useful to FMA members.

Gerold L. Schiebler, M.D., of Gainesville, Chairman of the Committee and Editor of *The Journal* welcomed the group and called upon each visiting editor to describe his publication and talk about his editorial problems.

The talks were so productive that the Committee decided to meet once a year with county editors in the future.

Guests photographed: (Top) Richard C. Dever, M.D., Miami; (Second Row) F. Norman Vickers, M.D., Pensacola (Escambia County); E. Charlton Prather, M.D., Orange Park; A. Lee Messer, M.D., St. Petersburg; Dr. and Mrs. Lees M. Schadel, Ft. Lauderdale (Broward County); (Third Row) F. Norman Vickers, M.D. and son, Frank, Pensacola; Governor M. Witt, M.D., Palm Beach (Palm Beach County); Louise Rader, Jacksonville; Edward D. Hagan, Jacksonville; (Last Row) G. L. Schiebler, M.D., Editor, Gainesville, chatting with Dr. Messer. These photographs were taken by John W. Glotfelty, M.D., of Lakeland (Polk County).

CHILD MENTAL HEALTH UNIT OPENS IN ATLANTA

The first private, comprehensive in-patient psychiatric service for children in Georgia has opened at Peachtree and Parkwood Mental Health Center and Hospitals in Atlanta, Georgia. Out-patient services and a day-care program are an integral part of this new service for children under 13 years of age.

TREATMENT PLAN

A multi-modality approach to psychiatric treatment is used and a comprehensive treatment plan is developed for each child. Psychiatric history, physical and neurological examinations, social history, educational evaluation and psychological testing determine the basic data upon which a treatment plan is devised.

The following types of treatment are used: individual psychotherapy (play therapy); group activities and group therapy; chemotherapy; parents and family therapy, and occupational, recreational, and music therapies. Special emphasis is placed on the family therapy process and treatment involves the family at every step.

MEDICAL SERVICES

Each child admitted receives a complete physical and neurological examination performed by the Center's pediatrician. This includes a medical history and necessary laboratory procedures, such as EEG, EKG, and fluoroscopic X-ray studies.

STAFF

The new Child Service is directed by a fully-trained child psychiatrist who has had previous experience with the direction of a child unit. Ten child psychiatrists and several child psychologists are involved in the program, and the staff works as a team in diagnosis, treatment and rehabilitation under the direction of a child psychiatrist.

NEEDED SCHOOLING AVAILABLE

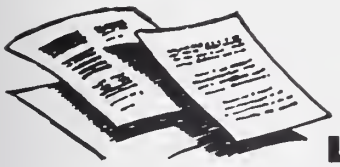
An educational evaluation determines the prescriptive teaching each child requires in the special educational program which is provided.

Peachtree and Parkwood is a comprehensive mental health center which includes alcohol rehabilitation and drug treatment as well as psychiatric treatment for adults, adolescents and children. Complete information on services and facilities may be obtained by writing or calling the Admissions Director:

PEACHTREE and PARKWOOD MENTAL HEALTH CENTER and HOSPITALS

1999 Cliff Valley Way, N.E. Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals



Letters

To the Editor: In 1974 I read the paper of Schiff in the Journal of the Florida Medical Association about detection of human seminal traces. (Schiff, Arthur F., Examining the Sexual Assault Victim, Sept. 1969, pp. 731-739). He wrote that positive qualitative reaction on acid phosphatase gives proof of presence of human seminal fluid. My opinion is that the positive test might never be proof of human seminal traces. All forensic pathologists in the German-spoken area have the same point of view and I think almost everywhere in Europe.

The test is insufficient as a substitution for detection of spermatozoa because it also gives a positive reaction to the acid phosphatase present in a host of other biological fluids: human urine, prostatic or seminal fluid of primates and other animals, milk, greens, flowers and other plants, snails, yeast and other bacteria. The test is a promising method as a screening procedure in suspicious areas but a positive result cannot possibly be accepted in the courts as proof of the presence of seminal fluid.

A quantitative measurement of acid phosphatase gives more information but, in cases of negative microscopical findings, only immunelectrophoretical methods with detection of specific proteins give the criminal court proof of presence of constituents of human seminal fluid.

Prof. Dr. G. Walther
D6500 Mainz
Langenbeckstrabe 1 (Bau 18)
West Germany

Dr. Schiff comments: This is a prime example of a sentence or a portion of a sentence out of context. The complete sentence is "In lieu of finding spermatozoa, the test is accepted in the courts as proof of the presence of seminal fluid." I am unfamiliar with what the courts do "in the German-spoken area," but now, as at the time the article was written, courts in the United States accept the test.

It is a very well known fact that the enzyme, acid phosphatase, is "present in a host of other biological fluids" and is a common traveler in nature, but is seldom found in such great amounts as it is in seminal fluid. In 1949 Kaye analyzed at least 38 substances including saliva, perspiration, pus, nasal discharge, beer, milk, mushrooms, French dressing, and alkaloids such as quinine and atropine along with many other substances unlikely to be found in the human vagina. No material was found to contain more than 5 King-Armstrong units of acid phosphatase per ml. of concentrated pure substance. In contrast, fresh seminal fluid ranged from 2000-2800 King-Armstrong units per ml. while decomposed seminal fluids had values of 800-1700 per ml.

Many laboratories, including our own Dade County Public Safety Crime Laboratory, view the test with some suspicion claiming there are too many false positive and employ it more as a screening test.

Several years ago I ran a series of 50 cases in which I first examined the vaginal fluid for spermatozoa, then, regardless of whether I did or did not observe spermatozoa, I performed an acid phosphatase test. In all instances where spermatozoa were present, the test was positive. In some cases where spermatozoa were absent, the test was still positive. Knowing the circumstances of the alleged attack, I felt the test to be correct and not a false positive. This little experiment gave me enough confidence to believe that the test can be relied upon in the hands of an experienced examiner. The examiner must insist, however, for his purposes of reporting, upon an immediate color reaction coinciding with the rate of color development of the positive control.

In the fall of 1973, Dr. Joseph Davis, Chief Medical Examiner of Dade County, wrote in a memorandum to all medical examiners and toxicologists: "Only an immediate color reaction is to be accepted as evidence of the presence of semen." I quite agree with his statement.

"Immunoelectrophoretical methods," particularly the work of Baxter in England, are known in the United States but it is felt by some that results are sometimes equivocal and more work is needed on these methods.

I wonder what prompted the letter after a latent period of at least five years?

Arthur F. Schiff, M.D.
Miami

Kaye, S.: Acid Phosphatase Test for Identification of Seminal Stains, J. Lab. Clin. Med. 34:728-732, 1949.
Baxter, S. J.: Immunological Identification of Human Semen, Med. Sci. & Law 13:155-165, 1973.

To the Editor: The American Academy of Family Physicians in its constituent state chapters, including the Florida Academy, comprise the nation's largest medical specialty organization. The Academy has been the official spokesman of family practice since its formation in 1947. Both national and state Academy efforts have placed the family practice movement in the limelight of American medicine and has been instrumental in getting appropriate recognition for busy family physicians before state and national legislatures, the public and within organized medicine.

The Academy is vitally concerned that any family physician know details of these other activities. I hope that interested family physicians will contact me so that I may send them important information about our activities. I realize that communication is a "two way street" and I will be delighted to send membership information to them so that they may make application to become an active member of the American and Florida academies and participate in the formation of our policies.

I look forward to hearing from them.

Arnold A. Oper, M.D.
Membership Chairman
Florida Academy of Family Physician
14701 N. W. 27th Avenue
Opa Locka, Florida 33054

To the Editor: A British physician's recent claim that he found the cause and a drug cure for rheumatoid arthritis is being refuted by rheumatologists in Florida and across the nation.

Statements of concern have been issued by both the Florida Society of Rheumatology and the Arthritis Foundation in New York after newspaper reports of alleged "cures" caused many arthritis patients to call and write for the new treatment.

Newspaper wire stories concerning the claims by Dr. Roger Wyburn-Mason, a consulting physician at two London hospitals, apparently stemmed from a reporter's interview with Dr. Wyburn-Mason after he presented a paper at the Ninth International Congress of Chemotherapy in London last July. According to the accounts, Dr. Wyburn-Mason claimed he isolated protozoa from the tissues of rheumatoid arthritis patients and concluded this may be the cause of the disease. However, according to a statement from the Florida Society of Rheumatology, "drugs used to treat protozoa have not been previously successful in treating rheumatoid arthritis."

The drug used by the London physician—Clotrimazole—is not an antiprotozoal drug, but is an antifungal agent used in the United States for externally treating fungal infections of the skin. Protozoal organisms and fungal organisms are not the same. Dr. Wyburn-Mason has no proof that Clotrimazole has any activity at all against the protozoa which he said he isolated.

We have contacted the laboratory which is testing Clotrimazole in the United States against fungal infections, and representatives of the firm deny that this drug has any significant effects against protozoa.

The following statement was made by Dr. Emmanuel Rudd, Medical Director of the Arthritis Foundation:

"The claims reported to have been made by Dr. Wyburn-Mason sound implausible to begin with. He apparently bases his treatment on the assumption that rheumatoid arthritis is caused by protozoal infection, but the report contains no data to show that he actually has isolated the infective agent. Furthermore, there is no reason given why a drug used for fungal infections should work in the treatment of protozoal infections.

"Dr. Wyburn-Mason is quoted as saying he has tried the drug on only 12 patients in what appears to have been an uncontrolled trial. I also question the way the patients were selected for

this small trial. To find out if any medication is effective and safe, tests must be conducted on hundreds of patients, requiring months or perhaps years to carry out. So it will take time to learn if Dr. Wyburn-Mason's findings prove to provide an effective treatment for rheumatoid arthritis. Meanwhile, there is nothing for arthritis patients to get excited about and I caution patients in the United States against possible false hopes and optimism based on the press story."

The drug is not generally available in Europe at the present time, so that it would be fruitless to travel to Europe to seek the drug treatment.

JACQUES CALDWELL, M.D., PRESIDENT
FLORIDA SOCIETY OF RHEUMATOLOGY
GAINESVILLE

Others Are Saying

As We Approach This New Year . . .

As we approach this new year, it is in many ways sad to see that organized medicine as represented by our county, state and national societies is playing an ever-decreasing role in actual post graduate medical education and is ceasing to be the major source of our medical information. Perhaps this was inevitable with the development and growth of the specialty and subspecialty organizations and their becoming ever more active in this increasingly complex task of our continued education.

If, as it appears, our role in education is decreasing, our role in quality control must increase. Whether one wishes to call it self-policing, self-discipline, self-evaluation, or peer-review, the meaning is the same. The Continuing Medical Education requirements for continued membership is just a start in this direction. Our purpose should be to insure delivery of the highest possible product, i.e., medical care, to the consumer at a reasonable price. And we must not lose sight of the fact that our profession's only reason for being is to serve our patients, the consumer. Our patients have a right to expect to be treated with technical skill as well as with understanding and compassion.

It is hoped that our organization can serve both our profession and our patients (the much-touted consumer) by helping to create a climate in which a degree of mutual trust and respect is again the accepted norm.

While we must work to bring about some desperately needed legislative changes, including the area of consumer responsibility, we cannot expect much help until and unless we recognize and correct our own deficiencies. One of our most visible deficiencies is the frequency with which complaints (justified and otherwise) by patients are met with a rather appalling degree of arrogance on the part of some physicians.

The role of this organization in the coming year should be to serve as a common ground of unity for our increasingly specialty-fragmented members with the goal of a common voice to present our aims to the general society.

Ralph M. Stephan, M.D.
Tampa

Reprinted from The Bulletin, Hillsborough County Medical Association, Inc., October 1975. Dr. Stephan is President of the Hillsborough County Medical Association.

Pain: a call to action.

- ☐ rapid acting
- ☐ effective, reliable oral analgesia in moderate to moderately severe pain
- ☐ oxycodone, the principal ingredient of Percodan, is one of the more readily absorbed oral narcotic analgesics
- ☐ one tablet q.6 h.*

Percodan® Tablets

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine (C II)

See Brief Summary

*See dosage and administration section of Brief Summary

Whenever an APC/narcotic is indicated.

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine

INDICATIONS: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

WARNINGS: *Drug Dependence:* Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients: Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN should be cautioned accordingly.

Interaction with other central nervous system depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children: PERCODAN should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

PRECAUTIONS: *Head injury and increased intracranial pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions. The administration of PERCODAN or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients: PERCODAN should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. The usual adult dose is one tablet every six hours as needed for pain.

DRUG INTERACTIONS: The CNS depressant effects of PERCODAN may be additive with that of other CNS depressants. See WARNINGS.

Aspirin may enhance the effect of anticoagulants and inhibit the effect of uricosuric agents.

MANAGEMENT OF OVERDOSAGE: *Signs and Symptoms:* Serious overdose with PERCODAN is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. The ingestion of very large amounts of PERCODAN may, in addition, result in acute salicylate intoxication.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine or levallorphan are specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of one of these antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug.

Endo Laboratories, Inc.
Subsidiary of E I du Pont de Nemours & Co (Inc.)
Garden City, New York 11530

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DYAZIDE®

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

the "empty nest syndrome"

TRIAVIL®

containing perphenazine and amitriptyline HCl
a tranquilizer-antidepressant

for depression with moderate anxiety

in many cases a result of the "empty nest syndrome"

The mid-life crisis: a critical crossroad

Preparation for change—intellectually, vocationally (or avocationally), and emotionally—can often help the menopausal-aged woman cope successfully with a new and different role after the children are grown and gone. Even when these changes have been anticipated and prepared for, a mid-life depression with moderate anxiety is not uncommon—a syndrome often uncontrolled by counseling or other appropriate measures and for which specific medication may be required.

When depression with moderate anxiety persists, TRIAVIL can often help

TRIAVIL provides a highly effective antidepressant and tranquilizer for symptomatic relief of *both* depression and coexisting moderate anxiety. The patient may be able to function more effectively in her daily life.

Many symptoms associated with depression and anxiety such as insomnia, fatigue, anorexia, and functional G.I. complaints, are frequently alleviated. More complete symptomatic relief is usually afforded than with an antidepressant or a tranquilizer alone. In fact, when anxiety masks the depressive state, treatment with just a tranquilizer may deepen the depression and delay symptomatic improvement.

Advantages of the two components in TRIAVIL taken together

A single tablet containing both an antidepressant and a tranquilizer encourages patients to take medication properly and reduces the risk of dosage confusion and error. Cost of therapy to the patient is usually less. To date, clinical evaluations have revealed no undesirable reactions peculiar to the combination. Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment.

Treatment with TRIAVIL—a balanced view

Contraindicated in CNS depression from drugs; in the presence of evidence of bone marrow depression; and in patients hypersensitive to phenothiazines or amitriptyline. Should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to other drugs or mask other disorders. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

For additional prescribing information, please turn to the following page.

for highly effective relief of depression with moderate anxiety

TRIAVIL®

containing perphenazine and amitriptyline HCl a tranquilizer-antidepressant

Available:

TRIAVIL® 2-25: Each tablet contains 2 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 2-10: Each tablet contains 2 mg perphenazine and 10 mg amitriptyline HCl

TRIAVIL® 4-25: Each tablet contains 4 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 4-10: Each tablet contains 4 mg perphenazine and 10 mg amitriptyline HCl

INITIAL THERAPY FOR MANY PATIENTS
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FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1—3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information.
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MEETINGS

Approved by FMA Committee on Continuing Medical Education

DECEMBER

National Conference on the Role and Training of the General Internist, Dec. 2-5, Americana Hotel, Miami Beach*

Florida Society of Ophthalmology Fall Meeting, Dec. 4-7, Innisbrook Resort and Golf Club, Tarpon Springs. For information: Susan Waits, Suite 346, Barnett Bank Bldg., Tallahassee 32301.

Practical Aspects of Human Sexuality, Dec. 4-7, University of Miami School of Medicine*

The Neonate With Congenital Heart Disease, Dec. 5-6, All Children's Hospital, St. Petersburg+

Intraocular Lenses—Instructional Lens Implant Symposium, Dec. 7-10, Americana Hotel, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Courses in Instruction in Coronary Care for the Practicing Physician, Dec. 8-13, Jackson Memorial Hospital, Miami*

Family Practice—Weekend, Dec. 12-13, International Inn, Tampa+

Nutrition in Serious Illness & Essential Diets, Dec. 12-13, St. Francis Hospital, Miami Beach. For information: St. Francis Hospital, 250 W. 63rd St., Miami Beach 33141

Recent Developments in Total Joint Replacement, Dec. 12-14, Miami*

"Severe Facial Injuries," Annual Meeting, Plastic & Maxillofacial Surg. Society, Dec. 12-14, Skycenter Inn, Jacksonville Airport, Jacksonville

Non-Invasive Methods of Cardiovascular Diagnosis & Treatment, Dec. 13-15, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Heart Association of Broward County, 440 N. Andrews Ave., Ft. Lauderdale 33301

Prosthetics & Orthotics, Dec. 15-17, Miami*

▸Medical Staff Law & Bylaws Seminar, Dec. 15-17, Key Biscayne Hotel & Villas, Key Biscayne. For information: Aspen Systems Corp., 11600 Nebel St., Rockville, Md. 20852

Cancer Conference: Management of Skin Neoplasia, Dec. 19, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

JANUARY

First Annual Postgraduate Seminar, Ultrasound and Nuclear Medicine, "Interrelated Roles in Medical Diagnosis," Jan. 4-7, Sonesta Beach Hotel and Tennis Club, Key Biscayne*

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 6-9, Key Biscayne Hotel, Key Biscyane*

13th Annual Postgraduate Seminar in Anesthesiology, Jan. 9-11, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Shock, Jan. 9-14, Halifax Hospital Medical Center, Daytona Beach. For information: Volusia Academy of Medicine, Clyde Morris Blvd., Daytona Beach 32014

The Role of the Medical Director in the Skilled Nursing Facility, Jan. 10-11, International Hotel, Tampa. For information: Philip H. Gilbert, Dir. Foundation Dept., Florida Medical Association, P. O. Box 2411, Jacksonville 32203.

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Vitreo-Retinal Symposium, Jan. 12-15, Key Biscayne Hotel, Key Biscayne*

Miami Winter Symposia, Jan. 12-16, Sheraton Four Ambassadors Hotel, Miami*

10th Annual Postgraduate Seminar in Surgery, Jan. 14-17, Eden Roc Hotel, Miami Beach*

Oral Surgery Seminar, Jan. 15-17, Fontainebleau Hotel, Miami Beach*

Emergency Cardiac Care: 1976, Jan. 15-18, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33136

Review & Recent Practical Advances in Pathology, Jan. 20-23, Deauville Hotel, Miami Beach*

Infectious Diseases: Treatment and Prevention 1976, Jan. 21-23, Konover House, Miami Beach. For information: Mt. Sinai Medical Center 4300 Alton Rd., Miami Beach 33140

Clinical Topics in Child Neurology, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Pediatric & Adult Urology Postgraduate Seminar, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Cancer Conference: Carcinoma of the Kidney and Renal Pelvis, Jan. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Current Concepts in Rheumatology, Jan. 23-24, Sonesta Beach Hotel, Key Biscayne. For information: Roy Altman, M.D., V.A. Hospital, Dept. of Medicine, Miami

Anatomic Pathology Workshop, Jan. 23-25, Deauville Hotel, Miami Beach*

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*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

▸National meetings being held in Florida.

Symposium "Frontiers in Diving," Jan. 24-25, J. Hillis Miller Health Center, Gainesville**

Continuing Education in Pediatrics, Jan. 26-29, Diplomat Hotel, Hollywood, Florida. For information: Variety Childrens Hospital, 6125 S.W. 31st St., Miami 33155

11th Annual Postgraduate Course in Internal Medicine 1976, Jan. 26-30, Fontainebleau Hotel, Miami Beach*

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Course in Hematopathology, Jan. 28-30, VA Hospital, Tampa+

Annual Cardiovascular Seminar, Jan. 30-31, University of South Florida, Tampa+

Twenty-First Central Florida Medical Meeting, Jan. 28-Feb. 1, Orlando. For information: Howard E. Gross, M.D., 15 W. Columbia St., Orlando 32806

▶Clinical Gastroenterology and Endoscopy, Jan. 28-Feb. 4, Doral Country Club, Miami. For information: Am. Soc. for Gastrointestinal Endoscopy, Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

FEBRUARY

Update Gastroenterology: 1975, Feb. 1-2, Americana Hotel, Miami Beach*

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Practical Problems in Clinical Cardiology, Feb. 2-6, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 2-7, Americana Hotel, Miami Beach*

Tenth Annual Symposium on Cosmetic Surgery, Feb. 5-7, Cedars of Lebanon Health Care Center, Miami. For information: Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Sex Counseling for the Physician, Feb. 5-7, Sheraton Towers, Orlando**

Midwinter Seminar in Obstetrics/Gynecology, Feb. 6-8, University of South Florida, Tampa+

Tumors of Infancy and Childhood, Feb. 6-8, All Children's Hospital, St. Petersburg+

Postgraduate Course in Clinical Allergy, Feb. 8-13, Sonesta Beach Hotel, Key Biscayne*

Second Annual USF Cancer Seminar, Feb. 14, Ft. Harrison Hotel, Clearwater+

Symposium in Perinatology, Feb. 18-20, University of Miami School of Medicine, Miami*

Immunological Mechanisms of Disease, Feb. 18-20, Hilton Hotel, Gainesville**

Medical Hypnosis for the Practicing Physician, Feb. 20, Aboard the SS Monarch*

Second Fred J. Woods Lecture Series, Feb. 21, St. Joseph's Hospital, Tampa. For information: Ralph Jensen, M.D., 3001 W. Buffalo Ave., Tampa 33607

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

"Hematology/Oncology Basic Review and Update," Feb. 26-29, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

Management of Nonsurgical Medical Emergencies, Feb. 25-27, University of South Florida, Tampa+

Cancer Conference: Diagnosis and Management of Ovarian Carcinoma, Feb. 27, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▶Contemporary Surgery, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▶Contemporary Ophthalmology, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Ophthalmology, 30 N. Michigan Ave., Chicago 60602

▶Contemporary Medicine 1976, Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▶Selected Topics in Cutaneous Medicine, Feb. 29-Mar. 6, Diplomat Hotel, Hollywood, Florida. For information: N.W. Dermatologic Soc., 1150 David Whitney Bldg., Detroit, Michigan 48226

MARCH

Infant Nutrition, Mar. 4-5, University of South Florida, Tampa+

Selected Topics in Urology, Mar. 4-6, Hilton Hotel, Gainesville**

Fifth Annual Postgraduate Seminar in Dermatology, Mar. 5-7, Hyatt House, Miami Beach*

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155

"Cardiology Update—1976," Mar. 12-13, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Sheraton Four Ambassadors Hotel, Miami*

Annual Suncoast Trauma Seminar, Mar. 18-20, Holiday Inn, Tampa+

"Ninth Annual Instructional Course on Surgery of the Hand," Mar. 19-21, University Hospital, Jacksonville. For information: JHEP, 655 West 8th St., Jacksonville 32209

Advanced Life Support: The Fourth Annual Postgraduation Seminar in Emergency Medicine, Mar. 19-22, Americana Hotel, Miami Beach. For information: Registrar, 1976 PGS, 1919 Beachway Rd., Jacksonville 32207

6th Annual Special Procedures Seminar: How and Why We Do it (Radiology), Mar. 21-24, Hyatt House, Miami Beach*

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

Inflammatory Bowel Disease, Mar. 25, University of South Florida, Tampa+

Seventh Annual Topics in Internal Medicine, Mar. 25-27, Gainesville Hilton, Gainesville**

Topics in Adolescent Medicine for the Practicing Physician, Mar. 26, Aboard the SS Monarch*

Cancer Conference: Management of Bone Tumors, Mar. 26, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Post-Convention Seminar: Anatomic-Pathologic Correlations in Pulmonary & Gastrointestinal Diseases, Mar. 28-31, (Cruise)*

Diagnosis and Management of Obstructive Airways Disease, Mar. 29-30, University of South Florida, Tampa+

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

Symposium in Perinatology, Mar. 31-Apr. 3, Sonesta Beach Hotel, Key Biscayne*

Renal Disease & Hypertension, Mar. 31-Apr.3, Americana Hotel, Miami Beach*

APRIL

Spring Symposium in Intensive Care, Apr. 2-5, Carillon Hotel, Hollywood, Florida*

"Advances in Endocrinology," Apr. 8-9, Skycenter Inn, Jacksonville International Airport. For information: JHEP, 655 West 8th St., Jacksonville 32209

▶Office Management of the Infertile Couple, Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608-13th Ave. S., Birmingham, Al 35205

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Asymptomatic Coronary Artery Disease: Early Detection & Management, Apr. 22-23, Hyatt House, Orlando**

Cancer Conference: Cancer Detection in the Physician's Office, Apr. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▶Symposium in Cardiovascular Nursing, Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

MAY

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

▶Gastrointestinal Endoscopy, May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Third Annual Family Practice Review, May 31-June 4, Hilton Inn, Gainesville**

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

JUNE

Bascom Palmer Eye Institute Annual Residents Day, June 1976, Key Biscayne Hotel, Key Biscayne*

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

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AMERICAN SOCIETY OF ANESTHESIOLOGISTS . . . has reelected Franklin B. McKechnie, M.D., of Winter Park, as Vice Speaker of its House of Delegates. Dr. McKechnie is a former President of the Florida Society of Anesthesiologists and is a member of the Executive Committee of the Orange County Medical Society.

SIDNEY BLUMENTHAL, M.D., OF MIAMI . . . has been named Director of the Division of Heart and Vascular Diseases of the National Heart and Lung Institute. The appointment is effective January 1.

MS. PAMELA HIGH . . . a medical student at the University of Florida has been appointed to the AMA Committee on Maternal and Child Care. She represents the American Medical Student Association.

CHARLES J. HEINBERG, M.D., OF PENSACOLA . . . has been honored by the Escambia County Medical Society for 50 years of active private medical practice.

The Society's October 14 meeting was dedicated to Dr. Heinberg, and a congratulatory resolution was presented to him. Dr. Heinberg, an otolaryngologist, served as President of the Escambia County Medical Society in 1933 and in 1952.

Resolution

WHEREAS October, 1975, will mark the 50th year of practice for Dr. Charles J. Heinberg; and

WHEREAS Dr. Heinberg has served both his community and profession with great distinction and honor during the long period of service; and

WHEREAS the Escambia County Medical Society wishes to express its appreciation to Dr. Heinberg, a distinguished Past President, and to honor him on this most significant occasion,

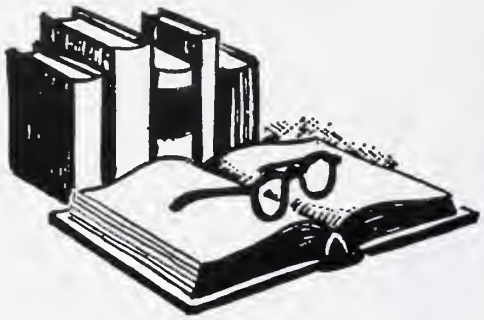
BE IT RESOLVED that the October meeting of the Escambia County Medical Society be dedicated to Dr. Heinberg's honor, and

BE IT FURTHER RESOLVED that by so doing, the society expresses its gratitude and heartfelt congratulations to Dr. Heinberg and wishes him many more happy years of active practice.

BE IT FURTHER RESOLVED that a copy of this resolution be spread on the minutes of the proceedings of the Escambia County Medical Society and that a suitable copy be presented to Dr. Heinberg.

Respectfully submitted,
John H. Whitcomb, M.D., President
John L. Pallin, M.D., Secretary-Treasurer
ESCAMBIA COUNTY MEDICAL SOCIETY
October 14, 1975

Dr. Charles J. Kahn, of Pensacola, presents Dr. Heinberg with the honorary plaque.



Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Editor's Note: Beginning with the October issue, F. Norman Vickers, M.D., of Pensacola, has been designated as Book Review Editor. With this appointment, The Journal hopes to bring to its readers an expanded coverage of selected topics of medical literature.

Additionally, in the firm belief that physicians should be well-read, certain books will be reviewed which are not solely medical, but which the Book Review Editor feels to be of special merit and interest to our readers.

Your suggestions and comments regarding this innovation will be welcomed.—The Editor.

Your Health Care and How to Manage It by Lawrence L. Weed, M.D. 194 Pages. Price $3.80. Essex Junction, Vermont, Essex Publishing Co., Inc., 1975.

Physician, heal thyself. For too long, the laity has regarded the physician as the Voice from Olympus; a voice never to be questioned; a voice of consummate authority over the bodies of his patients. Such an attitude has been perpetuated by the medical profession, according to Dr. Lawrence L. Weed, and has led to misunderstandings, mismanagement of health care and misuse of available resources. In *Your Health Care and How To Manage It*, Dr. Weed has offered one solution to these problems of modern medicine. He states that the "book was prepared on the premise that patients and potential patients must do their part to solve the overwhelming problems in health care."

To aid the patient in his quest for better health care, Dr. Weed explains the use of one tool with which both patient and doctor can work: the Problem Oriented Medical Record (POMR). The patient answers a questionnaire concerning his own and his family's health history, his home and business situations and his reactions to certain situations. The physician records test results, medications and treatment prescribed and the results of each. Dr. Weed contends that an understanding of POMR by the layman and the use of it by both patient and physician would result in better total medical care.

The author explains in depth what POMR is and how it works. For the most part, his explanation is readily comprehensible to the nonmedically oriented person. His use of football and automobile analogies are helpful to the layman in understanding a new medical system. However, Dr. Weed is sometimes guilty of the crime of which he accuses many physicians: noncommunication. In one of his case histories, he writes of a patient being "triaged" to another service in the hospital. Not many laymen would be familiar with this term.

Dr. Weed condemns practicing physicians not only for noncommunication but also for reliance upon memory. His thesis is that POMR eliminates this reliance and, therefore, will aid the doctor in treating the patient. The modern specialist, through the use of POMR, will become, in a sense, the old family doctor who knows all about his patient, his patient's family, his patient's business, etc.

The trouble with the system is that a whole new generation of physicians will have to come along before such widespread usage of POMR is effective. Dr. Weed claims that some medical schools refuse to teach this system to their students and many older physicians refuse to use it. These members of the medical profession will have to rethink their methods of patient care before POMR is universally accepted.

Dr. Weed's cure for such obstinacy on the part of physicians rests with the laity. He contends that patient understanding and utilization of POMR will convert the medical profession to its virtues. Samples of various POMR forms appear at the end of the book and the reader is encouraged to fill out his own POMR record. Members of the medical profession should, then, at the patient's insistence, complete the charts with the results of various tests. Through mutual cooperation, the patient's specific problem as well as any other general medical problems, would be thoroughly treated. Communication between doctor and patient should be open and complete. Thus, POMR can help the patient understand the various options concerning treatment of his problem if he takes time to study it and receives intelligible answers to his questions.

But, what if the patient can not find a physician willing to use POMR? Many physicians do not recognize its value. If the patient acts as a consumer shopping for the product which best suits his needs, it will cost him money. Few people will undertake a series of office visits with various physicians in order to find one who uses POMR.

This is the basic dichotomy of the book. It is intended for the layman and thoroughly explains a very useful medical tool to him, but the physician should also read and study Dr. Weed's book. Doctors must realize that they can no longer be Voices from Olympus. As the public becomes better informed about total med-

ical care, the members of the medical profession must also become better informed about the gripes of the layman. Physicians must communicate with their patients on the level of the patient's understanding, neither talking down nor talking over his head.

Your Health Care and How to Manage It is a much needed book for both the layman and the physician. The local banker can not cure the diseases of the medical profession just as the physician can not treat the ailments of the corporate body of the bank.

VIRGINIA PARKS
PENSACOLA

Virginia Parks is an intelligent consumer of medical services, thoughtful patient, writer, homemaker and parent of a medical student.
Book Editor's Note: *It seems reasonable that Dr. Weed's book, directed to patients, be reviewed by a perceptive lay person. Our prediction, however, is that this book will reach a small readership since the problem oriented medical record is but one small facet of the delivery of adequate medical care. F.N.V.*

In Defense of the Body by Roger Lewin. 146 Pages. Illustrated. Price $2.50. Garden City, New York, Anchor Press/Doubleday Company, 1974.

For those of us who went to school more than ten years ago and have trouble telling a T-cell (smooth) from a B-cell (bumpy) and IgG from IgM, this little book of 146 pages is a welcome addition to the library shelf. Written for the literate layman and comprehensive in scope, the book traces the history of immunology, under its various names and guises, from Jenner through Ehrlich to Burnet, from the 1790's to the 1970's.

The anatomy, physiology and genetics of immunology are unfolded in sufficient detail to be understood and yet briefly and clearly enough to hold the interest of someone who hasn't worked in a laboratory for many years. The last two chapters, "Tolerance and Intolerance" and "Cancer and Transplants," relate to some of today's most pressing clinical problems.

The bibliography is limited and the additional "standard texts" you are urged to consult are not mentioned by name; however, the index is comprehensive, the text is clear and the numerous illustrations, all line drawings except for electron microscope views of the bumpy B-cell and the smooth T-cell, are clear and understandable. Don't pass this one by!

LAWRENCE H. JACOBSON, M.D.
MIAMI BEACH

Beneficent Euthanasia edited by Marvin Kohl. 255 Pages. Price $10.95 (hardcover) and $4.95 (paperback). Buffalo, New York, Prometheus Books, 1975.

In an era when miracles of medicine and technology have removed the sting of death from many of the dreaded diseases of the last half century—at a time when we have the capacity almost infinitely to prolong the process of dying, at incalculable costs in pain and suffering, medical time and money—this book appeals for a reappraisal of some of those beliefs we have considered traditionally sacred. The twenty contributors form an international array of clergy, lawmakers, philosophers and physicians. Opposing opinions are presented but the openly stated purpose of the books is to make available some form of voluntary death with dignity. Legal, ethical and theological aspects of the question are thoroughly explored. A short anotated bibliography of additional readings is included as are a few notes and references at the ends of some chapters. "Beneficent Euthanasia" raises many questions and answers none—as these are things we must work out with our own minds and consciences. Dr. Walter Sackett's bill will again be before the Florida legislature in a future session. "Beneficent Euthanasia" provides the background for rational discussion of this issue.

LAWRENCE H. JACOBSON, M.D.
MIAMI BEACH

Autopsy by John R. Feegel, M.D. 300 Pages. Price $1.75 (paperback). New York, Avon Books, 1975.

It is neither *usual* or *customary* to review novels in these pages; however, it certainly seems *reasonable* that the first novel of our colleague and fellow Floridian, John Feegel, be reviewed here. Calling upon his native skill as a writer and story teller, plus his acquired skill as both forensic pathologist and lawyer, Feegel has produced a fast-moving, suspenseful tale about an apparent suicide which wasn't. Although portions of this book were a bit too clinical and earthy for my personal taste, his overall effort is exciting and praiseworthy. I look forward to reading his next work.

F. N. V.

If you don't know Cancer's Warning Signals, how do you know you haven't got one?

1.
2.
3.
4.
5.
6.
7.

1. Change in bowel or bladder habits.
2. A sore that does not heal.
3. Unusual bleeding or discharge.
4. Thickening or lump in breast or elsewhere.
5. Indigestion or difficulty in swallowing.
6. Obvious change in wart or mole.
7. Nagging cough or hoarseness.

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THIS SPACE CONTRIBUTED BY THE PUBLISHER

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Review of Medical Pharmacology, 4th Edition, by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. 821 Pages. Price $10.50. Los Altos, California, Lange Medical Publications, 1974.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Handbook of Pediatrics, 11th Edition, by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 703 Pages. Price $7.50. Los Altos, California, Lange Medical Publications, 1957.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

How to Beat Fatigue by Linda Pembrook. 223 Pages. Price $6.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975

Problem-Directed and Medical Information Systems edited by Marshall F. Driggs, M.D. 241 Pages. Illustrated. Price $15.45. New York, Intercontinental Medical Book Corporation, 1973.

Review of Physiological Chemistry, 15th Edition by Harold A. Harper, Ph.D. 570 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1975.

Handbook of Psychiatry, edited by Philip Solomon, M.D. and Vernon D. Patch, M.D. 705 Pages. Price $8.00. Los Altos, California, Lange Medical Publications, 1974.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

The Vitamin C Cookbook by Cory SerVaas, M.D. and Walter Mathews. 154 Pages. Price $6.95. Garden City, New York, Doubleday and Company, Inc., 1975.

Information for Authors

Manuscripts should be submitted to the editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

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Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Authors are responsible for the cost of making their illustrations into cuts. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

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Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

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Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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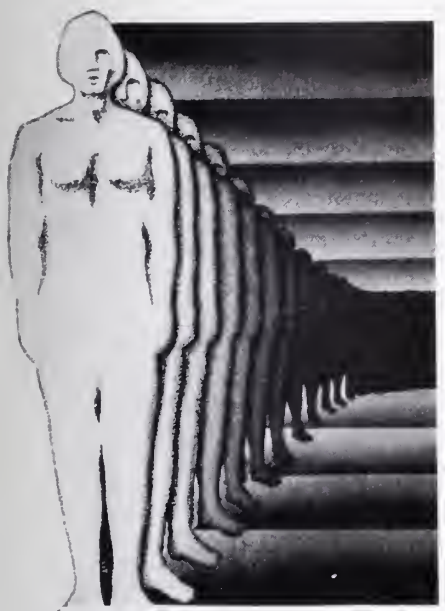

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Nutley, New Jersey 07110

LIBRIUM® C-IV

chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

IN PAINFUL ACUTE CYSTITIS*

*nonobstructed; due to susceptible organisms

RELIEVE THE PAIN

WHILE YOU ELIMINATE THE PATHOGENS.

FOR THE PAIN

☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Chilc
fonamide hypersensitivity
and during nursing perio
glomerulonephritis, sever
pyelonephritis of pregnar
disturbances, because of
component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl bottles of 100 and 500.

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